



# CROSSROADS COUNSELING

*emphasizing biblical hope & restoration*

## PREMARITAL INTAKE FORMS

Dear Friend,

Welcome to Crossroads Counseling. We are grateful that you have welcomed us into your life at this time. Marriage is an exciting and challenging blessing. We commend you for taking the time to put as much work into your marriage as you are your wedding at this busy time. It is our prayer that your work here will result in years of happiness.

Our goal at Crossroads is to provide the highest quality, Christ-centered counseling to couples as they prepare to be married. This means that the counseling you receive will focus upon helping you identify how the beliefs, values, and allegiances of your heart (Prov. 4:23; Matt 6:21; Luke 6:45) express themselves in your emotions, relationships, decision making, and identity. Your counselor will help you examine how your heart has been influenced and what your heart is currently seeking. Through intelligent and guided repentance, faith, and obedience we will seek to effectively love God and love your fiancé (Matt. 22:37-40) in order to experience the love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Gal. 5:22-23) God intends for us.

The next step in counseling for you is to complete the intake forms you are now reading. We have designed them to allow the counseling process to start smoothly. **You will need to allow 30-45 minutes to complete these forms.**

- You will find both map and written directions on the next page to allow you to find the office easily.
- The following six pages provide your counselor with background on your situation. These pages allow your counselor to get to know you more quickly and should help you organize your thoughts as you prepare for your first session.
- Finally, the last three pages contain the policies of Crossroads. Please read, initial, and sign these pages. If you have any questions, your counselor will be happy to answer them. Thank you for taking the time to complete these forms. Please bring them with you to your first appointment.
- Pre-marital counseling at Crossroads requires a minimum of eight sessions (six before the wedding and two after). Each session prior to the wedding will require eight to twelve pages of written homework, study, reflection, and conversation. Please make sure that you have allotted the appropriate time.

Office hours may vary, please contact the office for availability. Counseling sessions will require you to be in our office for approximately one hour. Please be prepared for this. Bathroom facilities are available. Childcare is not provided.

We are grateful to be able to serve you at this time and to be a part of the journey God has for you. We look forward with a sober anticipation towards playing a role in your progress and hope.

*Brad Hambrick*

Brad Hambrick, M.Div., Th.M., LCCT

*Executive Director*

Crossroads Counseling

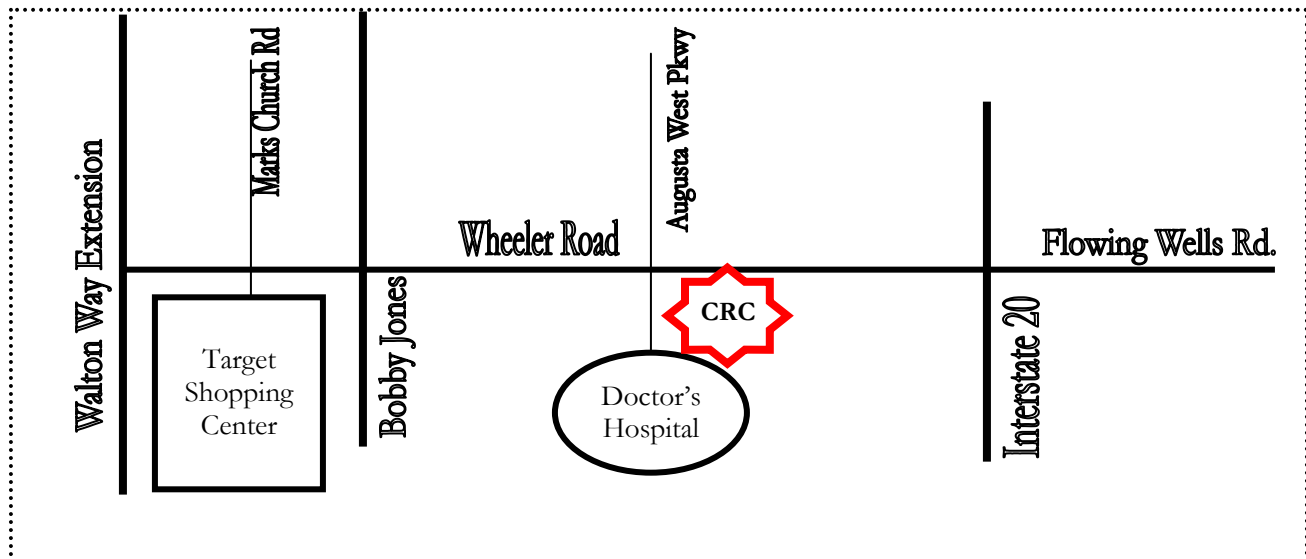
# DIRECTIONS TO CROSSROADS

## DIRECTIONS FROM I-20 & FLOWING WELLS RD:

At the I-20 intersection Flowing Wells becomes Wheeler Road. Drive down Wheeler Road until you come to the stop light in front of the Doctor's Hospital Complex. The hospital will be on your left and Rite Aid will be on your right. You will need to be in the far left lane and make a U-turn. **DO NOT TURN INTO THE DOCTORS HOSPITAL COMPLEX.** After making the U-turn, turn right into the **first** parking lot on your right (this will be the Boutwell Chiropractic building). On the first floor of the Boutwell building there are two office suites. Crossroads is the office on the right.

## DIRECTIONS FROM BOBBY JONES & WALTON WAY EXT:

Drive down Wheeler Road until you come to the stop light in front of the Doctor's Hospital Complex. The hospital will be on your right and Rite Aid will be on your left. **DO NOT TURN INTO THE DOCTORS HOSPITAL COMPLEX.** After passing through the light, turn right into the **first** parking lot on your right (this will be the Boutwell Chiropractic building). On the first floor of the Boutwell building there are two office suites. Crossroads is the office on the right.



PICTURE OF  
BOUTWELL BUILDING  
FROM ROAD SIDE



# PREMARITAL INTAKE FORMS

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: Male / Female Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip : \_\_\_\_\_

Please provide at least two(2) phone numbers: \_\_\_\_\_

Occupation / Employer: \_\_\_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security Number (*needed in case of emergency reporting*): \_\_\_\_\_

List highest degree(s) earned: \_\_\_\_\_

School or Institution: \_\_\_\_\_

**Fiancé Information:**

Name of Fiancé: \_\_\_\_\_ Your Fiancé's Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation / Employer: \_\_\_\_\_

List highest degree(s) earned: \_\_\_\_\_

Is fiancé planning to come for pre-marital counseling with you?    Yes     No     Uncertain

Who referred you to *Crossroads Counseling*? \_\_\_\_\_

How long did you know your fiancé before your were engaged? \_\_\_\_\_

How you and your fiancé date steadily before you were engaged? \_\_\_\_\_

How did you and your fiancé meet? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any previous marriages?    Yes     No

Give ***brief*** information about any previous marriages:

Ex-Spouse's Name	Year Married	Length of Marriage	Reason for Divorce	# Kids

*\* Other relevant information can be written on the back of this page.*

Child's Name	Age	Gender	Living	At Home	Married	Special Condition(s)	*PM/A/MC

*\* Check this column if child is by previous marriage (PM), adoption (A), or lost to miscarriage (MC).*

# SPIRITUAL / RELIGIOUS INFORMATION

DO YOU CONSIDER YOURSELF A RELIGIOUS PERSON? Yes  No

Church Name: \_\_\_\_\_ Church Attendance: \_\_\_\_\_ Times per month

Pastor's Name: \_\_\_\_\_

Denominational Preference: \_\_\_\_\_

What are you learning through sermons and bible studies at your church? \_\_\_\_\_

\_\_\_\_\_

Please list any ministry involvement: \_\_\_\_\_

Church attended in childhood: \_\_\_\_\_

HAVE YOU BEEN BAPTIZED? Yes  No  When? \_\_\_\_\_

If applicable, what is the religious background of your spouse: \_\_\_\_\_

Spouse's church attendance: \_\_\_\_\_ Times per month

DO YOU PRAY TO GOD? Yes  No  How often? \_\_\_\_\_

What do you pray about? \_\_\_\_\_

HAVE YOU COME TO THE PLACE IN YOUR SPIRITUAL LIFE WHERE YOU KNOW WITH CERTAINTY THAT IF YOU WERE TO DIE TONIGHT YOU WOULD GO TO HEAVEN?

Yes  No  Uncertain

If yes, what is your basis for answering the above question as you did? \_\_\_\_\_

\_\_\_\_\_

HAVE YOU RECEIVED JESUS CHRIST PERSONALLY AS YOUR SAVIOR?

Yes  No  Uncertain  Don't know what you mean

If yes, how do you know that Jesus Christ is your Savior? \_\_\_\_\_

\_\_\_\_\_

Do you read the Bible? Yes  No  How often? \_\_\_\_\_

Do you have personal devotions? Yes  No  How often? \_\_\_\_\_

Describe your personal devotions: \_\_\_\_\_

Do you have family devotions? Yes  No  How often? \_\_\_\_\_

Describe your family devotions: \_\_\_\_\_

Please note any recent changes in your spiritual life: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HEALTH INFORMATION

Have you had counseling, psychotherapy, or seen a psychiatrist before? Yes  No

Age	Duration	Counselor/ Center	Issue(s) / Topics(s) / Diagnosis	* Your Evaluation of Counseling

*\* Use back of this page if necessary or if you need more space*

Approximately how many hours of sleep do you get each night? \_\_\_\_\_

When do you normally: go to bed? \_\_\_\_\_ fall asleep? \_\_\_\_\_ wake up? \_\_\_\_\_ get out of bed? \_\_\_\_\_

What do you normally do between going to bed and falling asleep? \_\_\_\_\_

Describe any recent changes in sleep habits: \_\_\_\_\_

State of current health: Very good  Good  Average  Declining  Other: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Results: \_\_\_\_\_

Current illness, injury, or disability: \_\_\_\_\_

Are you presently taking any medication? Yes  No  Prescribing Doctor(s): \_\_\_\_\_

Medication	Dosage	Frequency	Prescribed for...	Date began taking...

*\* Use back of this page if necessary*

Have you used drugs for other than medical purposes? Yes  No  When? \_\_\_\_\_

What? \_\_\_\_\_ Amounts/Dosages: \_\_\_\_\_

Do you drink alcoholic beverages? Yes  No  When? \_\_\_\_\_ How much? \_\_\_\_\_

Describe your eating habits or changes in appetite: \_\_\_\_\_

Describe your exercise routine: \_\_\_\_\_

Your current weight? \_\_\_\_\_ lbs Weight changes in last 6 months \_\_\_\_\_ 1 Year \_\_\_\_\_ 5 Years \_\_\_\_\_

Number of non-working hours per week spent watching television \_\_\_\_\_ on computer \_\_\_\_\_ hobbies \_\_\_\_\_

Check any of the following words which best describe you **at this time**:

- |   |                                    |   |                                      |                                    |
|---|------------------------------------|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Active         | <input type="checkbox"/> Impatient | <input type="checkbox"/> Calm           | <input type="checkbox"/> Extrovert   | <input type="checkbox"/> Lonely    |
| <input type="checkbox"/> Ambitious      | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Serious        | <input type="checkbox"/> Likable     | <input type="checkbox"/> Shy       |
| <input type="checkbox"/> Self-Confident | <input type="checkbox"/> Moody     | <input type="checkbox"/> Easy-going     | <input type="checkbox"/> Leader      | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Persistent     | <input type="checkbox"/> Blue      | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Submissive  | <input type="checkbox"/> Introvert |
| <input type="checkbox"/> Nervous        | <input type="checkbox"/> Excitable | <input type="checkbox"/> Good-natured   | <input type="checkbox"/> Imaginative | <input type="checkbox"/> Quiet     |

Check any of the following struggles or difficulties that you are experiencing **at this time**:

- |  |   |  |                                    |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Anger                             | <input type="checkbox"/> Parenting            | <input type="checkbox"/> Eating Disorder                 | <input type="checkbox"/> In-Laws   |
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Depression           | <input type="checkbox"/> Guilt                           | <input type="checkbox"/> Fear      |
| <input type="checkbox"/> Apathy                            | <input type="checkbox"/> Marital Intimacy     | <input type="checkbox"/> Chronic Pain                    | <input type="checkbox"/> Envy      |
| <input type="checkbox"/> Bitterness                        | <input type="checkbox"/> Moodiness            | <input type="checkbox"/> Homosexuality                   | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Lifestyle Change                  | <input type="checkbox"/> Memory Loss          | <input type="checkbox"/> Addiction                       | <input type="checkbox"/> Deceit    |
| <input type="checkbox"/> Pornography                       | <input type="checkbox"/> Financial Management | <input type="checkbox"/> Suicidal Thinking               | <input type="checkbox"/> Grief     |
| <input type="checkbox"/> Communication                     | <input type="checkbox"/> Peer Pressure        | <input type="checkbox"/> Panic Attacks                   | <input type="checkbox"/> Work      |
| <input type="checkbox"/> Conflict Resolution               | <input type="checkbox"/> Relationships        | <input type="checkbox"/> Bad Memories                    | <input type="checkbox"/> Purpose   |
| <input type="checkbox"/> Security                          | <input type="checkbox"/> Compulsions          | <input type="checkbox"/> Self-Injury                     | <input type="checkbox"/> Identity  |
| <input type="checkbox"/> Procrastination                   | <input type="checkbox"/> Time Management      | <input type="checkbox"/> Codependency                    | <input type="checkbox"/> Family    |
| <input type="checkbox"/> Responding to Abuse (Type: _____) |   | <input type="checkbox"/> Psychological Diagnosis (_____) |                                    |

**Please provide the following information about your home of origin:**

If you were reared by someone other than your own parents, briefly explain: \_\_\_\_\_

Number of older brothers: \_\_\_\_\_ Older Sisters: \_\_\_\_\_ Younger brothers: \_\_\_\_\_ Younger Sisters: \_\_\_\_\_  
Step/half: \_\_\_\_\_ Step/half: \_\_\_\_\_ Step/half: \_\_\_\_\_ Step/half: \_\_\_\_\_

The town I grew up in was \_\_\_\_\_ urban \_\_\_\_\_ suburban \_\_\_\_\_ small town \_\_\_\_\_ rural \_\_\_\_\_ changed frequently.

My family's financial situation was \_\_\_\_\_ poor \_\_\_\_\_ lower middle \_\_\_\_\_ middle class \_\_\_\_\_ upper middle class \_\_\_\_\_ wealthy.

Did you have any significant traumatic events as a child? \_\_\_\_\_ Yes (*please describe on back*) \_\_\_\_\_ No

Which of the following words best describe your home of origin (check all that apply):

- |  |  |                                       |  |                                     |
|--|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Traditional     | <input type="checkbox"/> Authoritarian   | <input type="checkbox"/> Calm         | <input type="checkbox"/> Divorced      | <input type="checkbox"/> Lonely     |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Physical Abuse  | <input type="checkbox"/> Verbal Abuse | <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Critical   |
| <input type="checkbox"/> Sexual Abuse    | <input type="checkbox"/> Affectionate    | <input type="checkbox"/> Affirming    | <input type="checkbox"/> Safe          | <input type="checkbox"/> Permissive |
| <input type="checkbox"/> Unpredictable   | <input type="checkbox"/> Always Changing | <input type="checkbox"/> Boring       | <input type="checkbox"/> Other: _____  |                                     |

**Please complete the following:**

In order to understand me \_\_\_\_\_  
My ambition in life is to \_\_\_\_\_  
What really hurts me \_\_\_\_\_  
I get nervous when \_\_\_\_\_  
I wish I could lose my fear of \_\_\_\_\_  
What I wish I could change about myself \_\_\_\_\_  
My *best* childhood memory \_\_\_\_\_  
My *worst* childhood memory \_\_\_\_\_  
My father is/was \_\_\_\_\_  
My mother is/was \_\_\_\_\_  
My biggest regret is \_\_\_\_\_  
What I like/understand least about the opposite sex is \_\_\_\_\_  
My greatest achievement is \_\_\_\_\_  
My role in my current family is \_\_\_\_\_  
For refuge/rest I turn to \_\_\_\_\_  
When life gets too hard I \_\_\_\_\_  
To be happy I need \_\_\_\_\_  
I would do anything for \_\_\_\_\_  
I often wonder why \_\_\_\_\_  
It embarrasses me to \_\_\_\_\_  
I cannot decide \_\_\_\_\_





# CROSSROADS COUNSELING

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**Instructions for Policy Review:** Please read each of the policies on the following three (3) pages. After reading each policy please place your initials in the space provided to indicate your understanding and agreement with the stated policy. If you have any questions please direct them to your counselor prior to your initial meeting. If for any reason you are unable to sign these forms, counseling services will be denied to you.

## FINANCIAL POLICY

Crossroads is solely supported and able to operate because of your financial donations. The expenses of Crossroads are not underwritten by an individual, church, or corporation. Therefore, it is the responsibility of each counselee to maintain the operating expenses of Crossroads. The fair-market-value of counseling in the Augusta area ranges from \$75.00 to \$125.00 per 50-minute session. Your responsibility is to pray about the amount God would have you donate for the counseling you receive and be obedient to Him in your giving. Donations are expected at each visit.

\*\* Initial here if you understand and agree with this Financial Policy: \_\_\_\_\_

## APPOINTMENT CANCELLATION POLICY

We require a 24 hour notice if you wish to cancel or are unable to keep an appointment. Email is not an acceptable form of contact. If you fail to give us a 24 hour notice you will be expected to pay a missed appointment fee.

\$25.00 for the first appointment missed or cancelled with insufficient notice.

\$50.00 for the second appointment missed or cancelled with insufficient notice.

\$75.00 for all subsequent appointments missed or cancelled with insufficient notice.

\*\* Initial here if you understand and agree with this Cancellation Policy: \_\_\_\_\_

## PHILOSOPHY OF CARE

We are committed to providing a balance in our approach to counseling. It is our belief that all inner conflicts are both psychological and spiritual, because your mind, emotions, and will are always involved and because God is always present and His Word is always applicable. It is our goal to provide the highest quality of care that meets your specific needs and honors Christ.

We believe that our past helps shape our present beliefs and behaviors and also influences future beliefs and behaviors. We will address some of the strategies that obstruct us, the foundational issues of our identity, and outline practical steps on how to live by faith, renew your mind, manage your emotions, and resolve emotional trauma of the past or present through faith and forgiveness.

When necessary we will work with your physician to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

\*\* Initial here if you understand and agree with this Philosophy of Care: \_\_\_\_\_

## CONFIDENTIALITY CLAUSE

The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by our ethical principles in all but a few circumstances. Those exceptions are limited to the following: known or suspected child or elderly abuse; the intent to take criminal actions against another person; active suicidal ideations; and, counseling that is mandated by a legal authority, then it is assumed by your signature that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

Your counselor reserves the right to consult with other counselors at Crossroads for the purpose of providing the highest level of care. As a para-church ministry, Crossroads reserves the right to involve the church where you hold membership for the purpose of cooperative pastoral care.

In each counseling office and in the waiting room at Crossroads there are closed circuit video cameras. These cameras record picture only. They do not record voice. Video tapes are securely stored and made a part of Crossroads permanent records. Cameras are used exclusively for office protection and liability reduction.

\*\* Initial here if you understand and agree with this Confidentiality Clause: \_\_\_\_\_

## WAIVER OF LIABILITY

In seeking counseling from *Crossroads Counseling*, you must acknowledge your understanding of the following conditions and further release *Crossroads Counseling*, its agents, affiliates, counselors, employees, Board of Directors, and all ministry team leadership, from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. Counseling will be provided by ordained ministers or counselors licensed by the Georgia Board of Examiners for Christian Counselors and Therapists (Brad Hambrick, M.Div., Th.M.) or a counselor from a pastoral perspective (Celeste Vernon, M.A.). The counseling staff is *not* a state licensed counselor through the Georgia Composite Board;
2. All counseling is provided in accordance with the biblical principles adhered by *Crossroads Counseling* and are not necessarily provided in adherence to any local or national psychological or psychiatric association;
3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselors, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;
4. It is understood by the participant counselee(s) that all complaints and grievances will be heard by the Executive Director. If the goal of reconciliation cannot be achieved between the aforementioned parties, then the participant counselee(s) may elect to involve *Peacemaker Ministries, Inc.*, at their expense, for the purpose of mediation or arbitration.

\*\* Initial here if you understand and agree with this Waiver of Liability: \_\_\_\_\_

## CONSENT TO COUNSEL

Having read and understood *Crossroads Counseling's* Financial Policy, Appointment Cancellation Policy, Confidentiality Clause, Waiver of Liability, and Philosophy of Care,

I, \_\_\_\_\_ (print name)

grant permission for *Crossroads Counseling* to render counseling services to me and the names listed below:

_____	_____
_____	_____
_____	_____

I also understand that *Crossroads Counseling* may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, or for other issues agreed upon by the Board of Directors.

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### Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature (*if more than one client*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date