



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

YOUTH CLIENT INFORMATION

Name _____ Today's Date _____
Birth Date _____ Age _____ Sex _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
Email Address _____

Highest grade/degree completed in school and in what year? _____

Place and length of employment _____

If you could be anything or anyone you wanted, who or what would you be? (Be specific)

Boyfriend/Girlfriends Name _____ How long together? _____

Describe your relationship with your boyfriend/girlfriend?

Are you sexually active? _____

Family History

Brothers ages: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____
Sisters ages: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____

Circle your placement: 1 2 3 4 5 6 7 8 9 10 11 12

What kind of relationship did/do you have with your brothers and sisters? _____

Are you currently living at home? If not, how old were you when you left your parental home and why? _____



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

What kind of relationship did/do you have with your father and mother? _____

Was your parental home broken? _____ If yes, give your age and how you felt. _____

Did your father remarry? _____ Your age then? _____

Did your mother remarry? _____ Your age then? _____

How did/do you feel about your stepparent(s)? _____

Presently, I believe my spiritual condition is: poor fair average good excellent

Presently, I believe my physical condition is: poor fair average good excellent

Presently, I believe my emotional condition is: poor fair average good excellent

Physical Inventory

I believe my overall general health is: poor _____ fair _____ good _____ excellent _____

I generally sleep _____ hours a night.

Date of your most recent physical exam: _____



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Name of your physician: _____

List the names/purposes of medications or vitamins currently taking: _____

Do you have any disorders? _____

Is there a family history of disease or addiction? If yes, what and whom? _____

List any allergies: _____

Other physical problems: _____

Please answer YES or NO:

_____ I exercise on a regular basis.

_____ I eat foods that are healthy.

_____ I eat balanced meals on a regular basis.

_____ I eat junk food on a regular basis.

_____ I drink coffee. How much? _____ How often? _____

_____ I drink alcohol. How much? _____ How often? _____

_____ I smoke. How much per day? _____

_____ I have a complete physical exam yearly.

_____ I have periodic dental exams.



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Personal Information

If a female, have you had any discontinued pregnancies, abortions, or been involved with someone who has had an abortion? Please explain: _____

If a male, have you ever been involved with someone who has had an abortion? _____

Please explain: _____

Have you ever been institutionalized for any problem? _____ If yes, please explain. _____

Have you ever been arrested for something other than a traffic violation? _____ If yes, please explain:

Have you ever been involved with any activities associated with the occult? If yes, please explain, this would include Ouija boards, palm/psychic readings, tarot cards, new age religion, witchcraft:

Do you look forward to the future? _____

Circle the time period you think about the most: Past Present Future

Circle how you feel about the past: Guilty Bitter Confused Hurt Okay Good

Is there anything else you would like me know at this time? _____



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Circle experiences you have had in the **Past**.

Place a **check** next to what you are experiencing in the **Present**.

- | | | |
|--|--|--|
| <input type="checkbox"/> Grief | <input type="checkbox"/> Loss of faith in self | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Loss of faith in others | <input type="checkbox"/> Bitterness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feelings of going crazy | <input type="checkbox"/> Religious Doubts |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of faith in God | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Loss of hope | <input type="checkbox"/> Loss of meaning |
| <input type="checkbox"/> Loss of love | <input type="checkbox"/> Feelings of running away | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Excessive stress | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fantasizing |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Appetite change | <input type="checkbox"/> Acting out violence |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Loss of self-respect | <input type="checkbox"/> Anger with God | <input type="checkbox"/> Hatred |
| <input type="checkbox"/> Loss of feelings/thoughts | <input type="checkbox"/> Broken relationships | |
| <input type="checkbox"/> Moods high or low | <input type="checkbox"/> Addictive behaviors | |
| <input type="checkbox"/> Blaming others frequently | <input type="checkbox"/> Lack of sexual awareness | |
| <input type="checkbox"/> Hearing unseen voices | <input type="checkbox"/> Inability to express self | |
|
 | | |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Emotional | <input type="checkbox"/> Sexual Abuse or molestation by others |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Emotional | <input type="checkbox"/> Sexual Abuse or molestation to others |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Emotional | <input type="checkbox"/> Sexual Abuse to yourself |

This detailed information will allow me to understand your past and present in greater detail as we work together to bring healing and freedom to move forward in life. All information is kept in strictest confidentiality as required by the client and counselor privileged relationship.



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Kate Walpole MA

NCCA Licensed Clinical Pastoral Counselor

Licensed Clinical Christian Counselor

Certified Temperament Counselor

Consent for Psychological Services for Children

In order for minor children to receive counseling services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Please list the name(s) of child(ren) and date(s) of birth for each child to receive counseling services:

1. Name _____ DOB _____
2. Name _____ DOB _____
3. Name _____ DOB _____

Please list the name of the person requesting these services: _____

Your relationship to the child(ren): Parent _____ Stepparent _____ Grandparent _____ Guardian _____
Other _____

Are you the legal parent or guardian of the above-named child(ren)? Yes _____ No _____

I hereby swear that I have a legal right to obtain treatment for the above-named child(ren).

Yes _____ No _____

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, stepparent, grandparent, guardian, or other, you may be asked to provide a copy of the court order which names you the legal guardian of the above child(ren). Are you willing to do so? Yes _____ No _____

If you have joint custody, is the other parent willing to consent to counseling for the above named child(ren)? Yes _____ No _____

If the answer to the above question is NO, counseling services cannot be provided to the above named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider, Jennika Padilla of Cross and Crown Counseling, information regarding the nature and course of treatment of the child(ren).



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

I, _____, _____ consent to Kate Walpole of Cross and Crown Counseling to provide counseling services to the child(ren) named above. These services may include:

_____ Clinical interviews of the child(ren)

_____ Testing of the child(ren)

_____ Counseling/Psychotherapy

_____ Other services:

Signature of person giving consent _____ Date _____

Signature of person giving consent _____ Date _____



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Kate Walpole MA

NCCA Licensed Clinical Christian Counselor, Board Certified Clinical Supervisor

Certified Temperament Counselor

Youth Client Parental Information

Marital Status:

Single _____ Married _____ Divorced _____ Separated _____ Widow(er) _____ Cohabiting _____

Father's name: _____ Contact number: _____

Mother's name: _____ Contact number: _____

Address: _____

City _____ State _____ Zip _____

Email: _____

Describe your relationship with your spouse, partner:

If previously married briefly explain the length of marriage and reasons for dissolution

Please describe your concerns and expectations in bringing your child in for counseling services:

Are you willing to participate in independent or joint sessions if necessary, to work together on resolving conflict, restoring relationships and better understanding your child's temperament?

Yes _____ No _____



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Informed Consent and Confidentiality Agreement

Kate Walpole MA #W15361

I, _____ have been informed by Kate Walpole that Biblical Counseling and spiritual growth guidance are being provided and:

1. That Kate Walpole is an Ordained Minister of the Gospel and is a N.C.C.A. Licensed Clinical Christian Counselor; Licensed Clinical Pastoral Counselor, Certified Temperament Counselor and Board Certified Clinical Supervisor licensed by the National Christian Counselors Association, license #W15361.
2. Professional Christian counselors who are acting in a pastoral capacity are considered to be "Mental Health Professionals". This category may include church counseling staff, independent Christian counseling agencies, as well as commissioned or ordained Christian counselors.
3. The state of Oregon mandates that "all professionals must report or cause a report to be made and can not keep silent on the grounds of confidentiality or privileged communication," the following:
 - When a disclosure indicates a counselee may cause danger to self,
 - When a disclosure indicates a counselee may pose a danger to others, or
 - Child abuse.
4. That the counselee desires to take advantage of the Counselors services and training, and understands that the Bible will be the foundational basis for all counseling.
5. That the counselee also understands that he or she is responsible for any decisions the counselee makes regarding his or her life.
6. That Kate Walpole has explained fully to me, the counselee, all of the above prior to entering in to any counseling or disclosure.
7. That I freely and willingly accept and agree to abide by this Informed Consent as presented.

I also understand that all written and verbal information provided to the counselor throughout the duration of therapy services will be maintained under the strictest confidences unless disregarded by circumstances listed above in statement number three.

Signature of Counselee

Date

Signature of Counselor

Date



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

KATE WALPOLE #W15361

HEALTH INFORMED CONSENT

I, _____ have been informed by Kate Walpole that Biblical Counseling and spiritual growth guidance are being provided and:

1. That Kate Walpole is an N.C.C.A. Licensed Clinical Christian Counselor; licensed by the National Christian Counselors Association, license #W15361. She has a Masters in Clinical Christian Counseling is a Licensed Minister of the Gospel and a Board Certified Clinical Supervisor.
2. That Kate Walpole is not a medical doctor, she does not diagnose, or prescribe or cure any ailments mental or physical.
3. That Kate Walpole, in obedience to the Word of God disciple's clients in walking in freedom in Christ. The Word of God says "...that you would prosper, even as your soul prospers." Therefore Kate teaches her clients how to prosper (heal, grow, and be at peace inside themselves).
4. That Kate Walpole educates on issues of the soul, including relational, emotional, and brain health. The Word of God, says that He has given us every plant for healing, and the leaves of the trees are for the healing of the nations. Therefore, it is pastoral care for Kate to encourage and educate on soul care using nutrition and supplement information. She is not diagnosing, prescribing or curing anything. But only educating, so the client can make an informed decision about their own soul health.
5. That you, the client, must do due diligence to confirm with your medical doctor that anything suggested, through this education, by Kate, is approved by your doctor, and that Kate Walpole is not responsible for any choice you make from the education she gives you.

Signature of counselee

Date

Signature of counselor

Date



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

Cross and Crown Counseling Appointment Cancellation Policy

I, _____ have been informed by Cross and Crown Counseling of a 24 hour cancellation policy. I understand I can email a cancellation, cancel through the appointment scheduler online or leave a phone message. I also understand that if I cancel less than 24 hours of my appointment I will be charged a \$35.00 cancellation fee unless the cancellation was due to a true crisis situation.

Signature of Counselee

Date

Signature of Counselor

Date



177 SW Oak St. Dallas, OR 97338
(503) 917-1625

CROSS AND CROWN COUNSELING FINANCIAL MATTERS

Dear Friends,

We have a heart's desire to assist you with the help of the Lord, the Word of God, our professional training and life experiences. To keep this ministry continuing for you and others, please review the following:

The normal cost for private counseling at this level is \$105 per session. If you have an adequate household monthly income of \$4,800 or higher, we appreciate your support in that amount. For those who have lower incomes, you may refer to the sliding scale to determine your session fee. We request all clients to complete an online Temperament Profile questionnaire. The fee for the profile is \$55.

Payments are due at the time of the session. You can pay by cash, check, debit or credit card. Payment arrangements can be made for the Temperament Profile if needed.

A 24 hour cancellation notice is expected unless there are extreme or unforeseeable circumstances. If cancellation is made less than 24 hours prior to the session a \$ 35 late cancellation fee will apply. Please contact us as soon as possible if you need to reschedule your appointment.

Weekly Net Wages	Session Fee per Hour
\$ 1,200 or above	\$105
\$ 1,100 to \$1,200	\$95
\$ 1,000 to \$1,100	\$85
\$ 900 to \$1,000	\$75
\$ 800 to \$900	\$65
\$ 600 to \$800	\$55
\$ 400 to \$600	\$45
\$ Below \$400	\$35
Temperament Profiles	\$55

Date: _____

Client Signature: _____

Counselor Signature: _____