



Wisdom In Living Life Ministry, Inc.

P.O. Box 150 - Travelers Rest, SC 29690

www.wisdominlivinglife.org

(864) 834-9800 or (864) **271-HELP** (4357)

Application for Counseling

Are you interested in receiving counseling? Wisdom in Living Life Ministry, Inc. offers personal biblical counseling to a limited number of inquirers.

We would like you to know that our counseling is distinctly biblical and that we are not certified by the State of South Carolina. If you would like biblical counseling you may, at your discretion, pursue that desire with us.

Counseling cases may be initiated upon several conditions. They are listed as follows:

- All counseling will be conducted in accordance with the counselor's understanding of Scripture. Your counseling will be biblical in which the Scriptures are the final authority in all cases. If you are not sure that you will be interested in biblically based counseling, you have the option of attending one or two sessions to discover what biblical counseling is like. If you are unwilling to use the Bible as the final authority in counseling or unwilling to do the homework assigned, sessions will be terminated.
- Because of our commitment to the local church, we expect to maintain a relationship between counselor, counselee, and their respective local church. We recognize and respect the authority and discipline of the local church. We will expect you to be a member and regular attendee of a Bible preaching and believing church. If you are not a member of a local church, Wisdom in Living Life Ministry will assist you in finding one that can continue the care and accountability that you will need after the counseling process is complete.
- Information disclosed in counseling sessions will be held confidential only as the counselor believes the Bible or the State requires. Absolute confidentiality is not scriptural. In certain circumstances the Bible requires that facts be disclosed to selected others (Matt. 18:15-20). If your church leadership should inquire, we will disclose to them only that information, which we believe, is necessary for them to effectively and biblically fulfill their responsibility to shepherd you. However, your counselor will inform you, if possible, of such decisions beforehand.
- At any time during the counseling, for reasons sufficient to him/her, the counselor and/or the counselee shall have the option of terminating counseling.
- Wisdom in Living Life Ministry is a non-profit, faith-based service. Consider making a contribution to enable us to continue offering this service.

- We want you to understand that biblical counseling consists of giving scriptural instruction and the practical application of the same to each individual. Yet, the counselee is held fully responsible for how he/she implements that instruction.
- We are confident that the Bible has all of the information necessary for life and godliness (2 Peter 1:3). We believe there are no problems between persons which the Bible fails to address either in general or in specific principles. Our counselors are not infallible. Nor do they pretend to know all there is to know about biblical teaching and its applications to life. They are well equipped however, and competent to help people change. They will make a point to differentiate between God's commands and their suggestions. Furthermore, our counselors may at times, seek assistance from other trained counselors in their specific area of experience. We may have one or two persons assisting in your session.
- Please note that we do not give medical or legal advice.
- If a conflict should arise between the counselee and the counselor, both parties must agree to resolve the dispute outside the secular court system.

If you are interested in biblical counseling, please sign below as indicated.

If you are a parent or guardian of an under-aged child and you are requesting counseling for them, please sign below and enter the child's name who will receive the counseling. In addition, you have the option of sitting-in the counseling session(s).

I have read the conditions for counseling set forth in this Informed Consent Form. Furthermore, I agree to enter counseling in accordance with them.

Signed: _____

Spouse: _____ (*if applicable*)

Date: _____

Please Note

You have indicated that you wish to receive counseling through Wisdom In Living Life Ministry, Inc. We respectfully request that you read and that you answer all questions completely. Honesty is of primary importance as we cannot provide help if we do not have complete background information. Please understand that we will provide counseling services upon receipt of your completed form. Any form not completely filled out will be returned with those items highlighted that need to be completed.

Thank you for your cooperation.

Personal Data Inventory

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Today's date _____ E-mail address _____

Sex M__ F__ Date of Birth _____ Age _____ Referred by _____

Have you received counseling or therapy before? Yes ___ No ___ If Yes, list counselors and approximate dates:

Counselor(s) _____ Approx. Date(s) _____

Counselor(s) _____ Approx. Date(s) _____

What was the outcome? _____

Have you ever been arrested? Yes ___ No ___ If "Yes", explain briefly the situation(s):

How long have you lived in this area? _____ Where are you from? _____

HEALTH INFORMATION

Rate your current health: Very good ___ Good ___ Average ___ Declining ___ Failing ___

Height _____ Approx. weight _____ Recent weight changes _____

List every physician you have seen in the last two years (list regular physician first):

Doctor _____ Reason _____

Doctor _____ Reason _____

Doctor _____ Reason _____

Doctor _____ Reason _____

Date of last physical examination _____ Results _____

List all important illnesses, injuries, or handicaps (past or present)

Are you presently taking any medications? Yes ___ No ___ If Yes, list the medications and the Doctor that prescribed them (include all over-the-counter medications you currently use).

How many hours of sleep do you average per night? _____ Have there been any recent changes? _____

Is this sleep restful? _____ Do you have trouble sleeping? _____

Have you had any of the following physical problems? Please check:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Rashes
<input type="checkbox"/> Amnesia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Sensory Distortion
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Food Cravings	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Speech Problem
<input type="checkbox"/> Bowel/Bladder	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Memory Problem	<input type="checkbox"/> Stiff Neck
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Menstrual Changes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Unusual Hair Loss
<input type="checkbox"/> Change in Sex Drive	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Visual Problems
<input type="checkbox"/> Changes in Thinking	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Personality Changes	<input type="checkbox"/> Weakness
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hot/Cold Sensitivity	<input type="checkbox"/> Physical Changes	<input type="checkbox"/> Weight Change
<input type="checkbox"/> Constant Hunger	<input type="checkbox"/> Impotence	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>

RELIGIOUS BACKGROUND

Church currently attending _____ How long? _____

Church Address _____ City _____ State _____ Zip _____

Church's denomination or affiliations _____ Church phone _____

Pastor's name _____ Have you discussed this problem with your Pastor? _____

Does your Pastor know you are seeking counsel from us? Yes ___ No ___

Are you a member of your church? Yes ___ No ___ Baptized? Yes ___ No ___

Church attendance, times per month (*circle*) 0 1 2 3 4 5 6 7 8 9 10+

Have you ever been disciplined by a church? Yes ___ No ___ If Yes, explain:

Have you ever left a church for any reason other than moving from the community? If so, explain briefly:

Religious background in childhood _____

Do you consider yourself a religious person? Yes ___ No ___ Uncertain ___

Do you believe in God? Yes ___ No ___ Uncertain ___

Do you pray to God? Never ___ Occasionally ___ Often ___

Are you saved? Yes ___ No ___ Not sure what you mean ___

Do you believe you will go to heaven when you die? _____

Do you read the Bible? Never ___ Occasionally ___ Often ___

Explain any changes in your religious life in the last three years:

MARRIAGE & FAMILY INFORMATION

Name of Spouse _____ Date of Marriage _____

Address if different _____

Home Phone _____ Work Phone _____ Occupation _____

Spouse's Birthday _____ Age _____

Is your spouse willing to come with you for counseling? Yes ____ No ____ Uncertain ____

Your ages when married: Husband _____ Wife _____ Length of engagement _____

How long did you know your spouse before marriage? _____

Have you ever been separated? Yes ____ No ____ If Yes, when? From _____ To _____

Has either of you ever filed for divorce? Yes ____ No ____ If Yes, when? _____

Give brief information about previous marriages _____

Information about your children:

Previous Marriage	Name	Age	Sex	Education Level	Marital Status	Still Living?

Describe the home you grew up in: _____

How many older brothers and sisters do you have? brothers ____ sisters ____

How many younger brothers and sisters do you have? brothers ____ sisters ____

Are your parents living? Yes ____ No ____ Where do they live? _____

EDUCATION

Currently in: Middle School _____ High School _____ Other School _____ GED Program _____ Vocational Track _____

High School Graduate? _____ Year? _____ Received GED? _____ Year? _____

School currently attending _____ City _____ State _____

List the schools you have attended and certificates and/or degrees earned since high school:

School _____ Date(s) attended _____

Degree pursued _____ Field(s) of Study _____ Year graduated _____

School _____ Date(s) attended _____

Degree pursued _____ Field(s) of Study _____ Year graduated _____

School _____ Date(s) attended _____

Degree pursued _____ Field(s) of Study _____ Year graduated _____

EMPLOYMENT

Employer _____ Work Phone No. _____

Address _____

How long? _____ What other training or skills do you have? _____

Explain any employment changes in the past three years: _____

Does your present work satisfy you? If not, please explain: _____

Present annual personal income: _____ Household annual income: _____

GENERAL QUESTIONS

Have you ever had problems with the following? Check all that apply.

<input type="checkbox"/> Anger	<input type="checkbox"/> Finances	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Bizarre behavior	<input type="checkbox"/> Grief	<input type="checkbox"/> Relationships	<input type="checkbox"/> Vain regrets
<input type="checkbox"/> Depression	<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Self-control	<input type="checkbox"/> Worry
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Sexual abuse	
<input type="checkbox"/> Fear	<input type="checkbox"/> Lying	<input type="checkbox"/> Sleep problems	

Have you ever been sexually abused? Yes _____ No _____ What age? _____ If so by whom? _____

At what age was your first sexual experience _____? Male _____ Female _____.

What is the main problem as you see it? What brings you here? _____

When did it start? _____

What have you done about it? _____

What can we do? (What are your expectations?) _____

What kind of person are you? Describe yourself: _____

Is there any other information we should know? _____

What do you fear? _____

PATTERNS OF SUBSTANCE ABUSE

Do you sometimes use more of a substance than you had planned? _____

Do you find yourself frequently thinking about one of these substances? _____

Has a family member or friend ever expressed concern about your substance abuse?

Who? _____

Have you ever missed work or school due to intoxication/hangover? _____

Have you ever tried to "cut down" or stop using without success? _____

Have you ever experienced legal problems (arrests, DUI, etc.) due to substance abuse or possession?

Explain: _____

Have you ever undergone treatment for alcohol or substance abuse problems? Explain: _____

Do you have a substance abuse problem? _____

Describe your use of the following substances:

Substance	Age of first use	Frequency of use	Amount usually taken
Nicotine (Cigarettes)			
Tobacco (Dip, snuff)			
Inhalants			
Alcohol			
Prescription Drugs <i>(Please list type)</i>			
Marijuana			
Cocaine			
Crack			
Methamphetamines			
Heroin			
LSD			
Ecstasy			
GHB			
Ketamine			
Mushrooms			
Other <i>(Please list)</i>			