Journey Counseling Ministries
250 E Elizabeth Street, Suite 111
Harrisonburg, VA 22802
Phone: (540) 908-3464
www.journeycounselingministries.org

Date: _____
Referred by: _____
Church Home: _____

Clinical Intake Form

Demographic Information:

Full Name: _____ Date of Birth: _____ Age: _____ Sex: _____
If under 18, Parent/Legal Guardian: _____ Social Security Number: _____
Ethnicity: _____Religious Affiliation (active or inactive): _____
Education: High School: _____ College: _____ Other:_____
Occupation: _____ Employer: _____ Yrs at this job: _____ Phone #: _____
Military experience? Y/N _____ Combat experience? Y/N _____Where:_____
Branch/Length of service:_____ Type of discharge:_____

Contact Information:

Home Phone #: _____ Cell Phone #: _____
Email address: _____
Address: _____ City: _____ State: _____ Zip: _____
*Preferred form of contact: **Text**: _____ **Call**: cell: _____ home: _____ **Email**: _____*

Therapeutic Information:

What is your reason for seeking counseling? On a scale of 1-10 how distressing are these symptoms?

_____
_____
_____

When did these problems start? What was going on in your life at that time?

_____
_____
_____

What goals do you have? What do you hope to achieve through counseling?

_____
_____
_____

How motivated do you feel to work on things in therapy? (No Motivation) 1-10 (High Motivation)
Please describe:

_____
_____
_____

Current Household and Family Information

Marital Status: _____ If married, date married and years married: _____
Assessment of current relationship, if applicable: Poor_____ Fair_____ Good_____
Spouse's Name: _____ Date of Birth: _____ Age: _____
Spouse's Cell Phone #: _____ Spouse's Email Address: _____
Spouse's Occupation: _____ Employer: _____ Yrs at this job: _____ Phone #: _____
Previous Marriage(s): Name(s): _____ Duration: _____

*Please list the following **household information:***

Name	Relationship (parent, spouse, child, sibling)	Age	Sex	Type (bio, step, foster, etc.)	Living with you? Y/N

Family History

How would you describe your family of origin? (e.g. adjectives to describe your mom and dad)

Are you aware of any birth trauma your mom had during her pregnancy with you, or from age 0-3

Did you meet all of your developmental milestones? Are there any developmental concerns, learning disabilities, or other processing issues that we should be aware of?

Did you experience any abuse as a child in your home (physical, verbal, emotional, spiritual, or sexual) or outside your home? Please describe as much as you feel comfortable.

Have you experienced any abuse in your adult life? (physical, verbal, mental, emotional, sexual, spiritual, financial, etc.)

What are some of the key aspects of your culture that are significant to you

Legal History

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

Health History and Treatment Information

Your current health:_____Very good_____Good_____Average_____Declining

Please list any psychiatric diagnosis' that you have been diagnosed with in the past:

Please list any acute or chronic medical problems:

Please list current medication(s) and dosage(s) and purposes for medication:

List any sleep disturbances:

Please list any allergies: :

Primary Care Physician

Name: _____ Practice: _____ Phone:_____
Email: : _____ Dates in their care:_____

Do we have your permission to advise the physician that you are receiving care?
(if information is needed from your physician, then we will ask for completion of a different release of information)
◉ *No* ◯ *Yes (Coordination of Care will be sent to your PCP)*

Psychiatric History and Treatment Information

Have you previously sought clinical or psychiatric help: _____ Yes _____ No
***Counselor**: _____ Dates in their care: _____*
How satisfactory was your experience(s)? _____Very good_____Good_____Average_____Poor

What did you find **most helpful** in therapy?

_____
_____
_____

What did you find **least helpful** in therapy?

_____
_____
_____

***Psychiatrist**: _____ Dates in their care: _____*
How satisfactory was your experience(s)? _____
_____

Have you ever been hospitalized for any psychological or psychiatric reasons? _____ Yes _____ No
If yes, please describe when and where you were hospitalized, and for which reasons.

_____
_____
_____

Addiction History and Treatment Information

Do you currently use alcohol? _____Yes, _____No
If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely
If yes, how much do you drink? _____(#) per time.
Do you currently use Tobacco? _____Yes, _____No
If yes, how much do you smoke/chew? _____
Do you currently use Marijuana? _____Yes, _____No
If yes, how much do you smoke? _____
Do you currently use any illicit drugs? _____Yes, _____No
If yes, what drugs do you use? _____ If yes, how often do you use?
_____Daily, _____Weekly, _____Occasionally, _____Rarely

Please answer the following with a Y/N:
1. Have you ever felt you ought to cut down on your drinking or drug use? _____
2. Have you ever had people annoy you by criticizing your drinking or drug use? _____
3. Have you ever felt bad or guilty about your drinking or drug use? _____
4. Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started? _____

Have you received any previous treatment for substance use? Y/N _____
If so, where did you go?_____ Dates in their care_____
Was the treatment: _____Inpatient _____Outpatient
How satisfactory was your experience(s)? _____
_____

Do you currently attend AA/NA Meetings? (Or any other addiction support such as Celebrate Recovery, Ala-non, etc).
If yes, where did you go?_____
If yes, how often do you go? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Personal Strengths

What do you like about yourself?

_____
_____
_____

What activities do you enjoy and feel you are relaxed when you do them?

_____
_____
_____

What are your qualities and skills? What qualities have helped you to succeed at overcoming difficulties in the past?

_____
_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life?

_____
_____
_____

If applicable, how would you describe your spiritual life?

_____
_____
_____

Symptom Checklist:

*Please mark any of the following that apply in the **last 4 weeks**:*

Mood

- ☐ *Depression*
- ☐ *Anxiety*
- ☐ *Panic*
- ☐ *Hopelessness*
- ☐ *Helplessness*
- ☐ *Worthlessness*
- ☐ *Irritability*
- ☐ *Mood Changes*
- ☐ *Apathy*
- ☐ *Sadness*
- ☐ *Excited/Intense energy*
- ☐ *Anger/rage*
- ☐ *Feelings of guilt/shame*
- ☐ *Difficulty enjoying life or pleasurable activities*
- ☐ *Confused*
- ☐ *Unmotivated*
- ☐ *Feeling little emotion/numb*
- ☐ *Phobias if so, of what:*

  _____

Thinking

- ☐ *Suicidal ideation (thoughts to take your own life)*
- ☐ *Suicidal means to take your own life*
- ☐ *Suicidal plan to take your own life*
- ☐ *Hallucinations- seeing or hearing things that aren't there*
- ☐ *Hold strange beliefs that others don't share*
- ☐ *Intrusive negative thoughts*
- ☐ *Thinking the same thoughts repeatedly*
- ☐ *Flashbacks*
- ☐ *Rumination on past hurts/struggles*
- ☐ *Racing Thoughts*
- ☐ *Paranoia*
- ☐ *Inattentive*
- ☐ *Easily distracted/Difficulty concentrating*
- ☐ *Easily go off on tangents*
- ☐ *Grandiose thoughts*
- ☐ *Memory problems*
- ☐ *Low self-esteem*
- ☐ *Body Dysmorphia*
- ☐ *Indecisiveness*

Behavior

- ☐ *Self harm- if so, please describe:*

  _____
- ☐ *Obsessive compulsive behaviors- doing the same thing repeatedly*
- ☐ *Uncontrolled spending or gambling*
- ☐ *Increased use of alcohol*
- ☐ *Increased use of drugs*
- ☐ *Reckless behavior/impulsivity*
- ☐ *Increased financial problems*
- ☐ *Job change/work dissatisfaction*
- ☐ *Tearfulness*
- ☐ *Excessive crying*
- ☐ *Dissociation*
- ☐ *Isolating myself from others*
- ☐ *Hyperactivity*
- ☐ *Poor self-care*

Interpersonal

- ☐ *Increased conflict with partner/spouse*
- ☐ *Increased conflict with family*
- ☐ *Increased conflict with friends*
- ☐ *Increased conflict at work*
- ☐ *Difficulty making or maintaining friends*
- ☐ *Increased difficulty tolerating others*
- ☐ *Socially withdrawn/isolation*
- ☐ *Increased social anxiety*
- ☐ *Engage in risky sexual behavior*
- ☐ *Problems with intimacy*
- ☐ *Trouble with the law/authority figures*
- ☐ *Overly dependent on others*
- ☐ *Infidelity*
- ☐ *Divorce*
- ☐ *Grief*
- ☐ *Pregnancy*
- ☐ *Miscarriage/loss of a child*
- ☐ *Addiction*
- ☐ *Issues regarding remarriage/ blended family*
- ☐ *Birth of a child*
- ☐ *Abuse/Neglect*
- ☐ *Loneliness*
- ☐ *Spiritual Concerns*

Physical

- ☐ *Increased sleep*
- ☐ *Decreased sleep*
- ☐ *Difficulty falling asleep or staying asleep*
- ☐ *Nightmares/disturbing dreams*
- ☐ *Increased appetite*
- ☐ *Weight gain*
- ☐ *Binge eating*
- ☐ *Decreased appetite*
- ☐ *Weight loss*
- ☐ *Restricted eating*
- ☐ *Agitation/restlessness*
- ☐ *Sensory sensitivities (e.g. taste, smell, light, etc.)*
- ☐ *Headaches*
- ☐ *Tightness of chest*
- ☐ *Rapid heart rate*
- ☐ *Sweating*
- ☐ *Numbness or tingling*
- ☐ *Abdominal pain- Nausea/Diarrhea*
- ☐ *Difficulty breathing*
- ☐ *Panic attacks*
- ☐ *Shakiness/muscle tremors*
- ☐ *Muscle tightness*
- ☐ *Sexual difficulties/lack of desire*
- ☐ *Low energy/Fatigue*

Additional Information

- ☐ *Please share any additional information that you would like your counselor to know:*_____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- ☐ *Any other traumatic experiences not already referenced:*_____
  _____
  _____
  _____
  _____
  _____
  _____

Consent

Here is some general information we would like you to know regarding counseling at Journey Counseling Ministries. Please take some time to look this over. Do not hesitate to ask your counselor about any questions you may have.

Confidentiality & Treatment
As counselors, we place a high value on the confidentiality of the information our clients share with us. That means we will never divulge personal information without your consent except under the below conditions. Confidentiality of personal information is vital for building a solid therapeutic relationship. There are some very important exceptions to confidentiality that require the disclosure of personal information without your consent. We are legally obliged to take action to protect others from harm, even if we have to reveal some information about your treatment/evaluation/consultation.
1. ***Physical Threat:*** *Per Va Code 54.1-2400.1, if you threaten to harm either yourself or someone else and we believe your threat to be serious, we are obligated by law to take whatever actions seem necessary to protect people from harm. Also, by law, we are required to report to the proper agency any instances where we believe a child's welfare is at risk.*
2. ***Legal Proceedings:*** *If you are involved in any type of current or potential legal difficulties, we suggest that you discuss such matters with your attorney before informing us of the difficulties or informing others of the services you have received here. We also ask that you inform us of any current or potential legal actions at the time of your first appointment. This is so that we may be aware of the possibility that a subpoena may be issued requiring the release of confidential information.*
3. ***Cooperation with other Professionals:*** *If there is a need to share information in your records with someone not employed here (for example, your physician or another therapist), you will first be consulted and asked to sign a form agreeing to this action. You may wish to discuss the release of the material and related implications very carefully before you sign. The form will specify the information which you give us permission to release to the other party and will specify the time period during which the information may be released. You can revoke your permission at any time by simply giving us written notice.*
4. ***Consultation with other Professionals:*** *In order to continually improve our skills as therapists, we do ask other professionals for assistance on particular cases. In those instances, we protect the client's anonymity by not revealing personally identifying information.*
5. ***Records:*** *Personal information you share with us may be entered into your records. However, an effort is generally made to avoid entry of information which may be especially sensitive or embarrassing. The only individuals with access to our files are staff members who are directly involved in providing services to you. These individuals are aware of the strictly confidential nature of the information in the records, and persons from outside our office are not allowed access to our files.*
6. ***Insurance:*** *When insurance coverage is utilized it is considered consent on the insurer's part (client) that diagnosis and treatment plans and issues may be discussed by the therapist with your insurance company in order to facilitate insurance claim filing or case management with your insurance company. Check with your carrier for further clarification on their policies.*

Understanding the above, I/we give permission for _____ *to provide counseling to me/us.*
(Name of Counselor)

_____	_____	_____
Signature of client	*Printed name of client*	*Date*
_____	_____	_____
Signature of client	*Printed name of client*	*Date*
_____	_____	_____
Signature of Guardian ***(if client is minor)***	*Printed name of Guardian*	*Date*

Emergency Contact Information:

In the event of any medical or life-threatening emergency, I grant permission for my employee of Journey to contact the following person(s).

_____	_____	_____
Name	*Relationship to you*	*Phone number*
_____	_____	_____
Name	*Relationship to you*	*Phone number*

Please INITIAL each statement to which you consent.

_____ *I grant permission for information (billing, events, and other information) to be sent to my home address.*
_____ *I grant permission for my therapist and the administrative staff to contact me at my home phone #.*
_____ *I grant permission for my therapist and the administrative staff to contact me at my cell phone #.*
_____ *I grant permission for my therapist and the administrative staff to contact me at my business phone #.*
I grant permission for my therapist and the administrative staff to leave a message for me at my (please initial):
_____ *home phone* _____ *cell phone* _____ *business phone*
_____ *I grant permission for Journey to thank the person who referred me.*

I recognize that email and other forms of Internet communication are not a secure/confidential means to transmit data. By initialing any statement below pertaining to Internet communication, I voluntarily wave my rights provided by the HIPPA law, and any other federal or state laws regarding confidentially and the transmission of information via the Internet. I voluntarily give my permission and will not hold Journey and/or my therapist legally responsible for the transmission of this data.

*Client Signature*_____ *Date*_____
_____ *I grant permission to send and receive communication from my therapist at my email address.*
_____ *I grant permission to send and receive communication from Journey administrative staff at my email address.*

Finances & Appointments

Please INITIAL <u>ALL</u> statements:

_____ *I understand that Journey has a 24 hour cancellation policy. I will be charged the full rate of my session if I do not call at least 24 hours in advance to cancel unless I have a serious physical illness. If there are extenuating circumstances that I believe should affect this policy, I will discuss those with my therapist.*
_____ *I understand that counseling sessions last approximately 50 minutes including any time needed to schedule next appointments.*
_____ *I understand that my counselors current rate is $_____ per session and agree to be personally responsible for this rate. Should this rate change in the future, Journey will inform me in a minimum of 30 days in advance.*
_____ *I understand that if I become involved in legal proceedings that may require my counselor's participation, I will be expected to pay for their professional time for paperwork, court preparation, and appearing in court. Court preparation/appearance fee is $100/hr.*
_____ *I understand that Journey normally does not bill insurance companies. Should I want to submit my counseling for insurance reimbursement, Journey will issue a diagnostic receipt that I will submit to insurance and have the insurance company reimburse me.*
_____ *I agree to make payment at the beginning of each session. Payments may be made by cash, check, or credit card. Because Journey is a non-profit, and to minimize fees incurred with the use of credit cards, please pay by cash or check whenever possible.*
_____ *Checks returned by the bank for non-payment will be assessed a fee of $35, to cover bank charges and extra administrative time.*
_____ *I understand that if there is a change in my circumstances of employment, health, or other factors pertaining to my ability to pay, I will contact Journey Counseling to set up a payment plan or make arrangements.*
_____ *I understand that if my account is unpaid at 4 months a fee of 10% will be added to my outstanding balance. I also understand that I am fully responsible for collection costs or legal fees associated with collecting payment, should my account become delinquent.*

Observation for Training

Please INITIAL, if you consent:

_____ *Journey Counseling, at times, participates in training of interns and therapists. We would respectfully request that you consider allowing an intern to sit-in on your sessions with your counselor. Your session is always held in the strictest confidence and the trainee is bound by the same standards of confidentially as your counselor. Therefore, I agree to allow a trainee to sit in my sessions with my therapist if requested. I also understand that at any point, before, during, or after a session I can ask for the trainee to leave.*

_____ *I understand that my session may be videotaped for supervision and training purposes. This videotape will only be viewed by Journey counselors and will be erased after the supervision has taken place.*

_____ *I also agree to not audio or video record a session without the expressed knowledge and consent of my therapist.*

Policies

Please INITIAL all statements.

_____ *I have received, read, and understand the attached sheet "Journey's View of the Counseling Process."*
_____ *I acknowledge that I have received Journeys attached, written explanation of their compliance with HIPPA entitled "Notice of Privacy Practices."*
_____ *I understand that the release of marital/couple clinical records will require a signed release of information from both parties.*
_____ *I understand that both the law the standards of the clinical profession require that my therapist keep appropriate records. I am entitled to receive a copy of the records upon written request, with limited exceptions. Sometimes professional records can be misinterpreted and/ or can be upsetting, so Journey strongly recommends that I review them with my therapist so that you can discuss what they contain. My therapist will provide them to an appropriate mental health professional, with written request. Clients will be charged an appropriate fee for any preparation time to comply with a request.*

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (10/1/08), and will remain in effect until we replace it. We reserve the right to change our privacy practices and as applicable law permits the terms of this Notice at any time, reflecting such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment*: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.*
Payment*: We may use and disclose your health information to obtain payment for services we provide to you.*
Healthcare Operations*: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.*
Your Authorization*: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.*
To Your Family and Friends*: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.*
Persons Involved In Care: *We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.*
Marketing Health-Related Services*: We will not use your health information for marketing communications without your written authorization.*
Required by Law: *We may use or disclose your health information when we are required to do so by law.*
Abuse or Neglect*: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.*
National Security*: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.*
Appointment Reminders*: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).*
Telehealth Services: *To use Telehealth, you will need an internet connection and a device with a camera for video. Your counselor can explain how to log in and use any features on the Telehealth platform. If Telehealth is not a good fit for you, your counselor will recommend a different option. There are some risks and benefits to using Telehealth: The following risks of utilizing Telehealth include: Privacy and Confidentiality. You may be asked to share personal information with the Telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your counselor carefully vets any Telehealth platform to ensure your information is secured to the appropriate standards; Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your counselor will follow the backup plan that you agree to prior to sessions; Crisis Management. It may be difficult for your counselor to provide immediate support during an emergency or crisis. You and your counselor will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services. The following benefits of Telehealth include: Flexibility. You can attend therapy wherever is convenient for you; Ease of Access. You can attend Telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness. Here are the*

following recommendations to consider when utilizing Telehealth: Make sure that other people cannot hear your conversation or see your screen during sessions;Do not use video or audio to record your session unless you ask your counselor for their permission in advance; Make sure to let your counselor know if you are not in your usual location before starting any Telehealth session.

Social Media Policy: *Journey's counselors and staff will not accept friend or contact requests from current clients on any social media platform, which would potentially compromise client confidentiality and our respective privacy. Please do not utilize mobile texting or messaging on social media to discuss any other therapeutic topic except related to scheduling. Likewise, please limit emailing regarding the content of your therapy sessions since email is not a completely secure or confidential means of communication. In summary, please refrain from engaging in any form of online communication or publication, if there has been a client/counselor relationship.*

Patient Rights

Access*: You have the right to look at or get copies of your health information, within limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare as summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Restrictions: *You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).*

Alternative Communication*: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.*

Amendment*: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.*

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You may complain to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information.

Contact Officer: Clinical Director, Ally Padilla
Telephone: (540) 908-3464
Address: PO Box 14, Dayton, VA 22821

Journey Counseling Ministries
250 E Elizabeth Street, Suite 111
Harrisonburg, VA 22802
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View of the Counseling Process

The practice of counseling is based upon particular theoretical orientations as well as the personal style and experience of the counselor. Therefore, we believe it is in your best interest to briefly explain to you our background (as a group) as well as our views of the counseling process. We view the counseling process as forming an alliance with you, to explore the nature of your problem or personal struggle. Although we will spend much of our time exploring the specific problem that brought you into counseling, we will also explore, in depth, the nature of your relationship with other significant people in your life. In our theoretical orientation, we believe that many of the forces and dynamics that have influenced the complexity and intensity of your problem are rooted in relational issues. In using a ***Biblical foundation in our counseling****, we believe you are made to deeply relate—this is both a source of great joy and of deep pain. This is not to simplify your problem, but rather to highlight the complexity of the problem and how it interferes with the deep enjoyment for which you have been made. Aiming at the source of the problem is meant to give you hope.*

Interpersonal relationships are the areas in which the result of the brokenness of humankind is most prevalent, and in which the need for change is most obvious. In working toward the goals of removing the initial problem and growing in relational maturity, the counseling process will require that firm effort is made to change, which may involve significant discomfort. Remembering and resolving unpleasant events can arouse intense fear, anger, depression, frustration, and other powerful emotions that may feel foreign, but are a normal part of the process of growth. Seeking to resolve issues between family members, marital partners and other persons can similarly lead to discomfort, as well as relationship changes that may not have been originally intended.

Many of the results of counseling will depend upon your determination to deal honestly with the issues that powerfully affect your life. We are human beings who have been profoundly affected by the effects of brokenness in a fallen world. We are damaged people who do further damage through the way we handle our pain. We are tempted to transform our thirst for intimacy into things under our control that keep us feeling protected, yet, at the same time, in agony. This pain often appears in the form of symptoms such as depression, eating disorders, sexual dysfunction, anxiety, rage, etc. Your symptoms are important. They point beyond themselves to the need for an inside look into your life. This "inside look" is intended to surface—and over time disrupt—old, unhealthy dependencies and to offer the enticing idea that dependency on God is an invitation we have both feared and longed for in the core of our souls. We believe that certain problems can also have (or develop) physical components. In such cases, medical consultation will be advised.

The course of therapy is determined mutually by your counselor and you, the client. You are encouraged to freely ask any questions you have regarding the educational and professional background or therapeutic approach of your counselor. You are also encouraged to freely ask questions pertaining to your specific therapy plan and progress. ***People often ask how long they will be in counseling.*** *Some clients need fairly brief therapy to understand their conflicts and reach the goals they set for themselves. However, others may require many months or even years of work to achieve the growth they desire. We attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals, but we discourage clients from becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. Clients typically know when they are beginning to "feel finished" with therapy work. When this happens we encourage you to discuss this with your counselor so that we can close our relationship as carefully as it began. State certification requirements for professional counselors do not imply the effectiveness of treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful.*

It is always our intention to provide services in a professional manner that is consistent with ethical standards as described in the AACC Code of Ethics. If at any time in the course of your work with a counselor you feel that there may have been a misunderstanding or you have a question or complaint about your counselor's services, please bring this up immediately so that your counselor can become aware of your concern and resolve the matter with you.