SOURCE OF WELLNESS MINISTRIES, INC.

Christian Counseling & Wellness Education

For in Him we live, move, and have our being… Acts 17:28

MISSION STATEMENT:

Source of Wellness Ministries, Inc. provides a Christ-centered perspective to coaching, comforting, and empowerment through counseling and wellness education. We believe optimal health and wellness is attainable. Therefore, we incorporate a holistic approach to the Spirit-Soul-Body connection that allows you to live spiritually transformed, emotionally elevated and physically energized. **Source of Wellness Ministries, Inc.** seek to promote connection to God and encourages others to passionately pursue a well-balanced lifestyle. As you journey through this season, we are dedicated to seeing you live well, move well and be well.

POLICIES & PROCEDURES

General Information: All first-time clients are expected to fill out and sign our client intake form. Returning clients will update their intake form upon return for services. *We ask that you carefully read the information listed below.* Please be aware that some clients may be referred to other professionals since we do not specialize in addiction, children and career coaching. Please allow time prior to your scheduled appointment time to fill out necessary paperwork.

Qualifications: Tinasha "Tish" Gray is an ordained minister of the Gospel, wellness educator, and entrepreneur who is passionately living a well-balanced life that pleases the Lord. Her purpose in life is to empower others by educating and coaching individuals, couples and families who are on the path to living a balanced life in Christ. Tinasha holds a Bachelor of Arts degree in Psychology and Master degree in Pastoral (Christian) Counseling. She has 20 years of experience in holistic medicine, along with her background and knowledge in Biblical studies have allowed her to authentically communicate truth, with the purpose of transforming your life.

Client Confidentiality Policy: *All information provided by the client to the counselor will be kept in confidence.* The information will be used to design a treatment plan that will benefit the body, mind, and spirit connection of each client. We are required by law to report suspected abuse to children, elderly, or spouse. Suicidal and homicidal threats will also be reported to the nearest police station. The privacy of each client will be maintained at a high standard. Therefore, no discussion regarding confidential information will be discussed outside of the counselor's office. However, we may consult other counselors from time to time for supervisory purposes. **Please be informed that we will not testify in court regarding you or your case.**

Telephone Call: All phone calls more that 20 minutes will be billed accordingly. Please call or email again if your call or email is not responded to within 24 hours.

SOURCE OF WELLNESS MINISTRIES
Christian Counseling & Wellness Education

Dual Counseling Policy: Counsel from two or more counselors is an unethical practice and counterproductive. Dual relationships also hinder the effectiveness of the therapeutic relationship. Therefore we prefer you to be selective regarding your counselor.

Quiet Zone Policy: During your session, we ask that you limit all distractions. Please do not bring children with you and refrain from answering or using electronic devices during your counseling session.

Payment Policy: The fee per hour of counseling is $50. A debit or credit card will be required on file at the time of initial consultation. Full payments will be due at the end of your scheduled session. The card will be automatically charged in the event of late cancellations or no shows, in which case $50 will be charged to your card on file. **Source of Wellness Ministries** reserves the right to charge the card on file for the full price of the scheduled appointment. Payment options include cash, check, and credit or debit cards.

All payments obtained are final. There are no refunds (in the form of payment or services) nor exchanges of service. We do not accept insurance plans or Flex Spend Accounts at this time.

Late Policy: New Clients are advised to arrive 30 minutes early to fill out their initial paperwork. All repeat clients can arrive at least 5-10 minutes prior to their scheduled treatment time. We will not be able to accommodate late arrivals with an extended session. All late clients will be responsible for the full payment of their scheduled appointment.

Gifts: Contributions or monetary donations are welcomed for the support of other ministries affiliated to **Source of Wellness Ministries, Inc**.

Cancellation & Schedule Policy: *To cancel an appointment, we request a 24 hour notice*. To book or reschedule an appointment please email or call to secure an appointment time that best suits your needs.

CONTACT INFORMATION:

Tinasha "Tish" Gray

To schedule an appointment or wellness education workshop

Call: 404-491-1769 | Email: Info@sourceofwellness.org | www.sourceofwellness.org

SOURCE OF WELLNESS MINISTRIES

Christian Counseling & Wellness Education

CLIENT INTAKE FORM

All information provided will become part of your confidential records. This information will also assist in formulating specific goals for a desirable outcome.

PERSONAL INFORMATION

Name: *Date of Birth:* / / Age: M ☐ F ☐

Phone (Cell): *Email:*

Address:

City: State: Zip:

Occupation: # of Hours worked per week

Religious Affiliation: Active ☐ Inactive ☐

Education Level: GED ☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Ph.D ☐

Marital Status: Single ☐ Married ☐ (# Yrs.____) Divorced ☐ Separated ☐ Widowed ☐

Spouse Name: Age: Occupation:

Emergency Contact Name: Relationship
Phone:

Names of Children (Please specify if any Step-children) **M /F** **Age** **Occupation**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Parents Name (Please Specify if deceased) **Occupation (Note if Retired)** **Age** **Grade completed**

Father _____ _____ _____ _____
Mother _____ _____ _____ _____
Step-Parent _____ _____ _____ _____

List Sisters & Brothers (Please specify if deceased) **Relationship** **Age** **Occupation**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

How did you hear about us? ☐ Church ☐ Social Media (Facebook, Linkedin, etc.)
☐ Advertisement ☐ Seminar/Workshop ☐ Friend/Family - Referred By:

SOURCE OF WELLNESS MINISTRIES

Christian Counseling & Wellness Education

GENERAL HEALTH

1. Describe any physical problems you have at this time:

2. Are you currently under medical supervision? □Yes □No
   If yes, please explain:

3. Please list any medications you are currently taking:

4. Please list **ALL** allergies (skin/food/medicine) you have:

5. Did you receive previous Counseling or Therapy? □Yes □No

   If yes, where and with whom?

   How was your experience?

6. Do you consume Alcohol? □Yes □No
   When was your last use?

7. Do you consume Caffeine? (Coffee, Soda, Energy Shots, etc.) □Yes □No

COUNSELING REQUIREMENTS

1. Briefly describe the main problem that prompted you to seek counseling at this time.

2. Were there times when the problem was especially bad? □Yes □No
   If yes, when?

3. List any persons who play a major role in causing your problems.

4. List any person who helped you cope with the problems.

5. Please describe your goals for this Counseling session:

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Christian Counseling & Wellness Education

COUNSELING QUESTIONNAIRE

Please check the type of therapy you desire.

Please check each item to identify areas of concerns for

GENERAL THERAPIES OFFERED	SPECIFIC PROBLEMS
□ Pre-marital □ Marital □ Divorce Recovery □ Crisis/Short term □ Individual □ Inner Healing □ Family □ Deliverance □ Assertiveness Training □ Conflict Resolution □ Grief □ Parental Coaching □ Gift Analysis □ Growth Empowerment □ Stress Management □ Personal/Life Coaching □ Other: _____ □ Other: _____ □ Other: _____	□ Anger □ Fear/Worry/Anxiety □ Confusion □ Rejection/Abandonment □ Depression □ Unhappy with self/appearance □ Suicidal thoughts □ Education □ Work/Job related concerns □ Betrayal/Disappointment □ Physical problems □ Marital problems □ Financial problems □ Spiritual concerns □ Problems with children □ Problems with parents □ Sexual concerns □ Homosexuality □ Forgiveness □ People Pleasing/Approval Addiction/Guilt/Shame □ Eating Issues (Bulimia, Binge-eating, Anorexia) □ Addictions (Alcohol, Drugs, Relationship, Sex, etc.) □ Perfectionism/Compulsive behavior patterns □ Social problems (Isolation, Codependency, Peer pressure) □ Manipulation/Control

Please list your top six concerns from the list compiled above.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Christian Counseling & Wellness Education

ACKNOWLEDGMENT AND CONSENT TO THERAPY:

I have completed the intake forms to the best of my knowledge and I submit to counsel on my own free will. ***I affirm that I will not hold Source of Wellness Ministries, staff or its affiliated ministries responsible for the outcome of therapy.*** *I clearly understand that my counselor* ***will not*** *testify in court regarding any case I am involved in.*

I understand that my signature on the document represents my acceptance and willingness to adhere to the policies and procedures of ***Source of Wellness Ministries, Inc.***

Print Full Name: _____ Today's Date: _____

Signature of Client: _____

CONSENT TO TREAT MINOR (UNDER THE AGE OF 18):

I hereby authorize ***Source of Wellness Ministries, Inc.*** *to administer counsel to my child/dependent as they deem necessary.*

Print Full Name: _____ Today's Date: _____

Signature of Parent/Guardian: _____

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INFORMATION SHEET

Live Well, Move Well & Be Well

For in Him we live, move, and have our being... Acts 17:28

Our mission at Source of Wellness is to facilitate comfort, coach through education, and empower you to live well, move well and be well. The whole man is embraced as we minister to young adults, families, couples, and groups.
We believe optimal health and wellness is attainable. Therefore, we incorporate a holistic approach to the Spirit-Soul-Body connection through counseling and wellness education.

CHRISTIAN COUNSELING SERVICES OFFERED:

- Assertiveness Training
- Conflict Resolution
- Deliverance Ministry
- Divorce Recovery
- Family Therapy
- Gift Analysis
- Grief Counseling
- Inner Healing
- Life Coaching
- Epic Marriage & Pre-marital Counseling
- Parenting Classes
- Stress Management
- Upper Room Prayer
- Well-Balanced Life Seminars

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CREDIT / DEBIT CARD PAYMENT CONSENT FORM

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I authorize **Source of Wellness Ministries, Inc.** to charge my credit or debit card for professional services if I do not cancel before 24 hours. If I do not attend my scheduled appointment, I recognize that I will be charged the full fee for late cancellations or no shows.

I verify that my credit card information is accurate to the best of my knowledge. If this information is incorrect or fraudulent or declined, I am responsible for the entire amount owed and any additional costs incurred.

Client Full Name: _____

Name on card: _____

Card Number _____ Expiration Date ____/_____

Billing Address:_____

City: _____ Zip Code: _____ 3 digit CVC: _____

Signature: _____ Today's date: ___/____/_____