COUNSELING INTAKE FORM

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Date: _____

Referred by: _____

Please fill out this form and bring it with you to your first session. All information you provide is protected as confidential information.

Name _____
(Last) (First) (MI)

Address_____

City _____ **State**_____ **Zip** _____

SSN _____ **Insurance Co.** _____ **Ins ID #**_____

Home Phone _____ May we leave a message ___ Yes ___ No

Cell Phone_____ May we leave a message ___ Yes ___ No

Work Phone _____ May we leave a message ___ Yes ___ No

Email address_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Date of Birth _____**Age** _____**SSN** _____

Education: Highest level completed _____

Employment: Are you currently employed _____ Yes _____ No

If yes, place of employment and type of position_____

_____

Length of time at present place of employment _____

Marital Status: Check all that apply

Never Married __ Married __ Domestic Partner __ Divorced __ Separated __

Widowed __ Remarried __

Are you currently in a romantic relationship? __Yes __No If yes, for how long?

_____

On a scale of 1-10, how would you rate your relationship? _____

Relationships:

Spouse or partner's name _____

Length of relationship _____ Is Spouse or Partner Employed? ____Yes ____ No

Children:

First names	Ages	Who Living With	Do you have any concerns?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychological Background:
Have you previously received any type of psychotherapy or counseling?

_____ No

_____ Yes If so, with whom _____

When _____Reason _____

Are you currently taking any psychiatric medication? ? ____ Yes _____ No

If yes, who is your
physician?_____

Please list
medications:_____

_____

Have you previously been prescribed psychiatric medication? ____ Yes _____ No

Please list and provide dates: _____

_____

General Health and Mental Health Information:

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____Type _____

Depression:

Are you currently experiencing overwhelming sadness, grief or depression?

___ Yes ___No

If yes, approximately how long? _____

Anxiety:

Are you currently experiencing anxiety, panic attacks or have any phobias?

___ Yes ___No

If yes, when did you begin experiencing this? _____

Chronic pain:

Are you experiencing any chronic pain? ___ Yes ___No

If yes, please describe: _____

Alcohol / Drug Use:

Do you drink alcohol more than once a week? ? ___ Yes ___No

How often do you engage in recreational drug use? ____ Daily ____ Weekly

____ Monthly _____ Infrequently _____ Never

Family Mental Health History:

In the section below identify if there is a family history of any of the listed issues. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Circle	Family Member
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Bipolar Disorder	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	

How Can I Help? Please write a few comments describing your present situation and what goals you would like to set for your counseling.

When did this situation/condition begin? _____

Emergency:

In case of emergence who may we call?

Name_____Phone_____Relationship_____

Thank you for your attention to these questions. Your answers will be helpful.

HIPPA Notice of Privacy Practices

I have been given access to and read a copy of the HIPPA Notice of Privacy Practices associated with this counseling practice. I understand the guidelines and that I can request a written copy of full HIPPA regulations.

_____
Your Signature

_____
Date

Explanation of Counseling Services

I have received and read a copy of the Explanation of Counseling Services guidelines and procedures associated with this counseling practice. I both understand and agree to those guidelines.

_____
Your Signature

_____
Date

Cancellation Policy

If you fail to cancel a schedule appointment, I cannot use that time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hours notice unless it is due to a severe illness or emergency. Work related events are not considered an emergence. I both understand and agree to this policy.

_____
Your Signature

_____
Date

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, I am required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, I am required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children or Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
I am required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minor/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-part payers are given information they request regarding services to clients.

Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Your Signature (Client's Parent/Guardian if under 18)

_____
Date

Problem Checklist

Name_____ **Date** _____

In order to help us identify and understand your concerns, please take a few minutes and indicate in the boxes below what concerns you have and the degree to which you are troubled by these concerns. Please choose a number from 1 to 5 with 1 indicating "little or no concern" and 5 indicating "very concerned". Thank you.

0 no concern _____ **5 very concerned**

Example: If you were having problems getting along in your family, you would put a 4 or 5 in the blank below. 5	1. I have problems relating to members of my family	2. I am afraid that I won't find a suitable mate	3. I am having difficulty sleeping	4. I have experienced panic attacks	5. I am afraid my "significant other" is cheating on me
6. I am afraid I may be loosing my mind	7. I am feeling guilty about past behavior	8. I am afraid I may hurt someone in the future	9. Loss of appetite, or other problems with food	10. I feel depressed most of the time	11. There are thoughts that I can't seem to get out of my head
12. I experience extreme "highs" and "lows"	13. I am afraid I may have an eating disorder	14. I have problems relating to members of the opposite sex	15. I am having frequent and severe headaches	16. I often feel helpless and /or hopeless	17. I am afraid I will lose my job
18. I am experiencing problems of a sexual nature	19. I experience problems with my anger	20. I am having problems with drugs (including alcohol)	21. I am afraid of heights &/or crowds, &/or small spaces	22. I am afraid I may not be in touch with reality	23. I have thoughts of suicide
24. I was sexually abused as a child	25. I was physically and/or emotionally abused as a child	26. I am in an abusive &/or dysfunctional relationship	27. I am experiencing difficulty with PMS	28. I am experiencing feelings of loss and/or grief	29. Other _____

SENTENCE COMPLETION QUESIONNAIRE

Name:_____ Date: _____

These sentences are all about you and what you think and feel about different areas of you life as it is now. Read each sentence and complete the sentence with the first thought or feeling that comes into your mind. Please be honest and frank in your answers since this will assist us in helping you. You may use the back of the sheet if you which to comment or add anything. Please take a few moments to complete this form and return it to the office on your next visit.

1. People cannot understand why I _____

_____

2. More than anything else I need _____

_____

3. I am often afraid of _____

_____

4. When I am afraid, I _____

_____

5. Nobody knows _____

_____

6. I often wish I _____

_____

7. I get mad when _____

_____

8. When I get mad, I _____

_____

9. I feel best when _____

_____

10. I feel terrible when _____

_____

11. When I feel bad, I _____

_____

12. I get excited when _____

_____

13. I only harm myself when _____

_____

14. My greatest fault _____

_____

15. I would like to make myself _____

_____

16. I can never forget the way my father _____

_____

17. People in positions of authority _____

_____

18. It is difficult for a man/woman to _____

_____

19. If my husband/wife would only _____

_____

20. Compared with my father, _____

_____

21. I suffer most _____

_____

22. One of the problems in sex is _____

_____

23. I am afraid that _____

_____

24. It's hard to resist the temptation to _____

_____

25. Sexual intercourse for me would be better if _____

_____

26. I get uneasy when _____

_____

27. My problems seem to begin when _____

_____

28. It really feels like punishment when _____

_____

29. I try to get along in a group by _____

_____

30. The way to deal with a person who opposes you is _____

_____

31. When I feel sad and hopeless, I _____

_____

32. Compared with my mother, I _____

_____

33. My parents always treated me as if _____

_____

34. My temper _____

_____