Counseling Intake Form

*This form is intended to help your counselor become better acquainted with you and, in turn, serve you better. **Please print** the information requested or checkmark the appropriate responses. You may omit any item but try to be as thorough as possible. Thank you.*

Name _____ Today's Date: _____

Birthdate _____ Age: _____ Marital Status: S / M / D / W

Address _____ City _____ Zip _____

Phone _____ Messages: Okay voicemail ___ Ok other person ___ no messages ___

Email Address: _____

Referred By: _____

Emergency Contact Information

Name _____ Relationship _____

Address _____ City _____ Zip _____

Phone _____ Messages: Okay voicemail ___ Ok other person ___ no messages ___

List Others Living in the Home, and all children

Name	Relationship	Age

Presenting Problem

Briefly describe why you are seeking counseling: _____

_____

_____

How would you rate the intensity of the problem or concern that let you to seek counseling? (please circle)

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

Approximately how long have you had this current problem or concern? _____

What would you like to accomplish in therapy?

1. _____
2. _____
3. _____

Cultural Background

What is your race/ethnicity?

___ White
___ Asian American
___ Black/African American
___ Native Hawaiian/Pacific Islander
___ Hispanic/Latino
___ American Indian/Alaskan Native
___ Multiracial (please specify)_____
___ International (please specify) _____

How much do you identify with your ethnic heritage?

____not at all ____ a little ____somewhat ____strongly

Social Background

Please describe any relationships in your family and/or social network that are significant sources of stress or conflict for you:_____

_____

_____

Please list those individuals (name/relationship) who are a source of emotional support to you:

_____

_____

Education and Occupational Information

Please indicate your educational level:

___ Less than high school
___ H.S. equivalent/GED
___ High School Diploma
___ Vocational
___ Some College (no degree completed)
___ Bachelor's Degree
___ Master's Degree
___ Doctoral Degree
___ Other

Are you currently employed? ___ no ___ yes Are you currently in school? ___ no ___yes

If yes, who is your current employer/position/school? _____

Please list any work/school-related stressors, if any _____

_____

Primary Care Physician and Physical Health History

Name _____ Phone _____

Address _____ City _____ Zip _____

How would you rate your overall health at present? ___ poor ___ fair ___ good ___ excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

Please list any medications you are currently taking, the dosage, and the condition they treat:

_____

_____

Mental Health History

Have you had previous counseling? ___no ___ yes Please describe previous experience (How long ago? Was it positive or negative? What was helpful/unhelpful? Etc.): _____

_____

Have you ever been diagnosed with a mental health related illness? ___ yes ___ no

If yes, what? _____

Have you ever been hospitalized due to your mental health? ___ Yes ___ No

If yes, when and why? _____

Please list any medications (including dosage) you currently take that are meant to address your mental health: _____

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with mental health? ___ no ___ yes If yes, please describe: _____

Have you had suicidal or homicidal thoughts recently?

___ frequently ___sometimes ___rarely ___never

Have you had them in the past?

___ frequently ___sometimes ___rarely ___never

Substance Use History

Do you currently drink alcohol? ___ yes ___ no

If yes, what alcoholic beverages do you drink?

___ Beer ___ Wine ___ Liquor ___ Mixed Drinks ___ Other: _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

___ daily ___ weekly ___ monthly ___ rarely ___ never

Do you currently engage in recreational drug use? ____ yes ___ no

Have you used recreational drugs in the past? ____ yes ____ no

If yes to either, what drugs have you/do you use? _____

_____

How often do you/have you used these drugs?

___ daily ___ weekly ___ monthly ___ rarely ___ never

Do you currently use any tobacco related products including vaping, smokeless and smoked tobacco? ___ yes ___ no Have you used them in the past? ___ yes ___no

If yes, what kind of product(s) do you use? _____

If yes, how much and/or how often do you use? _____

Have you tried to quit using tobacco related products before? ____ yes ____ no

If your alcohol, drug, or tobacco consumption was different in the past compared to now, please describe your past use (when, how much, how often): _____

_____

_____

Would you like help with decreasing and/or discontinuing use of alcohol, recreational drugs, and/or tobacco products? Check all that apply:

_____ Yes, Alcohol _____ Yes, Drugs ____ Yes, Tobacco

In the list below, please place a “C” next to items you currently experience and a “P” next to items you have experienced in the past.

alcohol use		feeling overemotional		sexual function problems	
angry mood		race/ethnicity/cultural concerns		seeing strange things	
anxiety or fearfulness		grief/death of a loved one		significant weight change	
bingeing/purging		hearing strange voices		sleeping more or less than usual	
change in appetite		guilt		social isolation	
confusion		hopelessness		suicidal thoughts	
depressed mood		Hyperactivity or restlessness		homicidal thoughts	
drug use		irritability		non-suicidal self-harm	
elevated mood		laxative/diuretic use		compulsive behaviors	
parenting problems/DCS involvement		mood swings		poor concentration	
loss of interest in things		obsessive thoughts		relationship conflicts	
restricted eating		panic attacks		racing thoughts	
emotionally harmed by others		victim of physical harm		loss of motivation for things	
medical problems		struggling with hygiene		past suicide attempts	
fatigue/low energy		sexually harmed by others		unemployment	
nightmares		problems falling or staying asleep		financial stressors	
frequent relocations or homelessness		marital problems		legal problems/incarceration/probation	

Religious/Spiritual Information

Do you consider yourself to be religious? ___ yes ___ no

If yes, what are your faith/spiritual beliefs and how do they impact your daily life? _____

_____

Have you ever been hurt by someone related to religious or church issues? ___ yes ___ no

Church Affiliation: _____

Would you like Christian faith to be included in the counseling process? ___ yes ___ no

Assets and Strengths

What are your special interests and hobbies? _____

_____

_____

What do you see as your personal strengths? _____

_____

_____

What values are important to you? _____

_____

Is there anything else you want me to know about you? _____

_____

_____

The information requested below is used for grant requests essential to our organization's funding. We compile data anonymously. Your individual data is not shared. Thank you for your honesty.

1. Do you have health insurance? ___ Yes ___ No

   If yes, does it cover mental health care? __ Yes ___ No

2. What is your approximate total *monthly* household income? _____

   How many people live in your household? _____

TO BE COMPLETED BY COUNSELOR

Client is a: ___ Resident ___ Non-resident

Counselor's Name (please print): _____ Counselor's Initials: _____

Clinical focus/impressions: _____

Fee Amount Agreed Upon: _____

****Your counselor will ask you to complete the following form periodically throughout therapy to help gage your progress. ****

Client Name: _____ Date Completed: _____

The Warwick–Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick–Edinburgh Mental Well-being Scale (WEMWBS)
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For Office:

Counselor's Name: _____

Please turn photo copy of completed form in to "Completed WEMWBS Folder" in top middle drawer. Keep original in client chart.

Repeat every 6 sessions.*

Informed Consent for Counseling Services

Therapist: Counseling Intern

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding the contents before signing it. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Counseling Philosophy. The philosophy of Hope Alive is to provide high quality, comprehensive counseling services at a low cost. Hope Alive retains a professional volunteer staff as well as highly trained professional employees. Hope Alive provides a variety of counseling services including individual, couples, family, group, and individual counseling. Hope Alive retains a spiritual approach while remaining accepting of all clients regardless of their beliefs and values. Hope Alive is a nondiscriminatory provider. No one shall be denied services based on race, religion, gender, sexual orientation, ethnicity, age, or handicap. Our goal is to assist our clients in obtaining skills, beliefs, and faith necessary for them to develop and maintain their mental, social, emotional, physical, and spiritual well-being.

Information About Your Therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns. If, at any time, you believe that I am not an appropriate fit for you and your needs, please inform me so that I and my supervisors can discuss the best course of action in moving forward. It is important that you feel completely comfortable with me and that your best clinical interests are met.

Fees. The rate per counseling hour for services rendered for individuals, couples or family counseling is $25.00. If that fee is not affordable, a reduced rate that is within your means will be negotiated. No one is refused services due to lack of ability to pay. Fees for counseling are to be rendered at the time of service. Hope Alive is not set up to receive third party payments such as insurance.

Risks and Benefits of Therapy. Counseling, or psychotherapy, is a process in which we will discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Counseling is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors such as individual effort, approach, level of trust,

and honesty. Hope Alive cannot predict or guarantee the results of counseling. Clients are encouraged to participate in counseling planning and participate in the expected outcome of counseling.

Participating in therapy may result in several benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self- confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and other different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships and/or behaviors is your sole responsibility.

During the therapeutic process, some people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result. Clients have the right to accept or refuse counseling.

Counseling Approach. It is my intention to provide services that will assist you in reaching your goals. During therapy, I will draw on various treatment approaches, according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, existential, and/or psycho-educational techniques. Sometimes more than one therapeutic approach can be helpful in dealing with a certain situation. *If, at any time, I, or my supervisor, believe your needs are beyond my scope of expertise or skill, appropriate referral services will be offered.*

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used during your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining that treatment.

Confidentiality. Clients have the right to confidentiality. The information discussed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Counselors may have to share information with other counselors at

Hope Alive in order to ensure proper and continual care. Additionally, I regularly share case information with my supervisors, and possibly student peers in an educational setting, to enhance my skills and to ensure you are receiving the best care. My colleagues at Hope Alive, supervisors and student peers, are all bound by the same rules of confidentiality. The only reasons confidentiality will be broken are: 1) client exhibits the potential harm to oneself; 2) client exhibits the intention to harm another; 3) client reports child or adult abuse, neglect, or exploitation.

Termination of Therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you, I, or my supervisor, determine that you are not benefiting from treatment, any of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy, It is best to discuss this in a planned termination session if at all possible.

Also, it is important that you be aware that my clinical practice at Hope Alive is in conjunction with a finite period of education and/or professional training. When my training period, or internship is complete, I will work with you to make arrangements to see a new, qualified therapist if not all treatment goals have yet been met. I will be in conversation with you as this necessary change approaches and we will, at that time, determine which course of action is best for you, which may include terminating treatment, transferring to a new therapist at Hope Alive, or receiving a referral to a new therapist elsewhere.

Professional Supervision, Consultation and Collaboration. Professional consultation is an important component of a healthy psychotherapy practice, not just for students-in-training. However, as a student-in-training, I am legally and ethically required to participate in regular clinical supervision with university educators and faculty members, as well as with a site-specific clinical supervisor. This supervision includes weekly meetings between myself and my supervisors during which client cases are reviewed for the purpose of developing my professional skills, in addition to case consultation and assuring quality client care and safety. Additionally, I may be required to participate in group or peer-supervision. I may be periodically required to audio/video record my sessions so that my supervisors can observe and review my skills. I will never record our sessions without your consent. My site supervisor at Hope Alive is listed below and can be contacted at Hope Alive with any concerns you may have regarding the care you receive from me.

Clinical Supervisor at Hope Alive: Dawn L. Etzel, MA, Licensed Mental Health Counselor #39002304A, Licensed Addictions Counselor #86000311A, National Certified Counselor #251725.

Additionally, in order to provide quality services, I may need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Virtual Supervision. It may be necessary from time to time for me to meet with my supervisor(s) through "virtual supervision" or using electronic media such as online video conferencing or telephone. When this is done, reasonable efforts are made to ensure the confidentiality of the information disclosed over electronic media, including, but not limited to, using such electronic means only in private spaces, never sharing client identifying information, and using HIPAA-compliant video conferencing software. However, the media utilized are not guaranteed to be encrypted; therefore, there is still a risk, albeit small, of an unwanted breach of information. I encourage you to talk with me about any concerns you may have in this matter. If you do not wish for me to receive virtual supervision concerning our work, you may make such a request in writing.

Records and Record Keeping. I may take notes during the session and will also produce other notes and records regarding your treatment. These notes constitute my clinical records, which by law, I am required to maintain. Such records are the sole property of Hope Alive. Clients may review the notes kept in their file in the presence of a counselor.

Letter Writing. You need to be aware that as a counselor-in-training, I am not qualified to write or provide any letters to any entities (e.g. attorneys, disability determination boards, certifying agencies, etc.) which may request professional or clinical determinations, opinions, assessments, or recommendations. Furthermore, while my clinical supervisor oversees my work, she, having never met you personally, is not able to provide such letters either. Therefore, please be aware that any such letter requests will be denied and unable to be fulfilled. If you are coming to services with the need to acquire such a letter, or suspect one may be needed in the future, please inform me so that I may provide you with an appropriate referral to a qualified mental health professional.

Text and Email Contact. Using email or text messaging can be easy and convenient forms of communication, especially for scheduling purposes. However, I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. While phones and email may be password protected, email and text messages transmitted through regular services are not encrypted. This means that a third party may be able to access information in a message and read it, especially if you are using a work-related email address or phone. If you should choose to communicate with me via text or email, you are choosing to do so at your own risk. Furthermore, while I try to return messages in a timely manner, **I cannot guarantee immediate response and request that you DO NOT use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. PLEASE USE EMAIL AND TEXT MESSAGES FOR SCHEDULING PURPOSES ONLY.**

Social Media. I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Appointment Scheduling and Cancellation Policies. Scheduled appointment times are reserved especially for you. It is important for you to notify me as soon as possible if you are unable to attend a scheduled appointment as this not only shows respect for my time but also the availability of that slot

for another client in need. If an appointment is missed or canceled with less than 24 hours' notice, you may be charged the full fee for that missed appointment. If you miss 2 appointments without notice, you may not be allowed to reschedule with this office. Furthermore, if you cancel 3 appointments without reasonable cause, you may not be allowed to reschedule. Exceptions may be made if you are sick or have an unavoidable emergency.

Therapist Availability / Emergencies. You may leave a message for me at any time on Hope Alive's confidential voicemail at (260) 420-6100, ext. 101. Please be aware that messages left after business hours are not retrieved until the next morning and messages left after 5:00pm on Thursdays are not retrieved until after 9:00am on the following Monday. **Please understand that as an intern, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room.**

Acknowledgement and Consent to Treat

By signing below, I am certifying that I have read and been offered a copy of Hope Alive's Informed Consent for Counseling and agree to the terms, limitations and considerations stated therein. I have discussed such terms and conditions with my therapist and have had any questions with regard to its terms and conditions answered to my satisfaction. I am acknowledging that I am voluntarily accepting counseling. I understand that I will be charged $25 (or the agreed upon rate of $_____ Counselor Initials:____ Client Initials:_____) per session and I agree to pay this fee to the best of my ability. I understand that I am free to terminate the counseling relationship at any time for any reason except court ordered. I understand that I am taking full responsibility for any or all consequences resulting from my reactions to, or decisions made as a result of counseling. I accept all responsibility and agree to hold harmless all individuals associated with Hope Alive.

Client Name (Please Print): _____

Client Signature: _____ Date: _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Informed Consent to Participate in Distance Counseling or Telemedicine

In order to increase access to counseling services, as well as avoid interruption in services in some circumstances, counselors can provide distance counseling or "telemedicine". Telemedicine involves the use of electronic communications, such as online video software or telephone, to enable services when the therapist and the client are in two different locations. Before engaging in distance counseling, I am ethically required to inform you of the possible risks of benefits of utilizing such a service.

Expected Benefit:

- Improved access to counseling services when factors, such as transportation, weather, illness, etc., inhibit the counselor and therapist from meeting face-to-face.

Possible Limitations and Risks:

- Distance counseling, especially via telephone, limits the counselor's ability to read client body language and other non-verbal cues, which may impact the interventions used and the overall course of therapy. It is possible that, despite the counselor's best efforts at attunement, you may feel your counselor cannot "read" you as accurately as in face-to-face meetings. Furthermore, misunderstandings and miscommunications can happen.
- Some counseling interventions are difficult if not impossible to implement via distance counseling; therefore, choosing to engage in distance counseling may limit which interventions your counselor may utilize in your treatment.
- Technology failure may temporarily interrupt, inhibit, or even end sessions without notice.
- In very rare instances, despite efforts at utilizing confidentiality-conscious technologies, security protocols could fail, causing a breach of privacy and personal information.
- While counseling treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Results cannot be guaranteed or assured.

You have the right to give consent to participate in distance counseling, as well as the right to revoke that consent at any time. Giving consent to distance counseling does not preclude you from participating in face-to-face sessions when we are able.

By signing, you are acknowledging that you and I have discussed the risks and benefits of distance counseling and have deemed it appropriate for your needs. You are acknowledging that the same rules and limits of confidentiality apply to distance counseling as face-to-face sessions. You are acknowledging you understand that, if at any time, I or you believe that distance counseling is not in your best interest, or if I or you determine that distance counseling is ineffective, we will discontinue using it in leu of face-to-face meetings only. If I am not able to provide you with face-to-face meetings, I will assist you in identifying appropriate referral resources.

_____ _____

Client Signature Date

Client Printed Name: _____

_____ _____

Client Email (to be used for distance counseling) Client Phone (to be used for distance counseling)

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Hope Alive, Inc. Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, I acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

Hope Alive, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

☐ **Accepted Notice**

_____
Signature of Client

_____
Client's Date of Birth

_____
Date

☐ **Declined Notice**

_____
Signature of Personal Representative

_____
Description of Personal Reps. Authority

I authorize the following person(s) minimal access (does not include copies of medical records) to my protected health information (PHI):

Name	**Date of Birth**	**Home Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client's signature: _____
For authorization to release limited PHI to the above listed individuals.

☐ I further authorize Hope Alive, Inc. to communicate with me electronically through e-mail at the following e-mail address: _____. **I understand that this email communication is not secured by encryption therefore is not considered a secured or private communication. Hope Alive, Inc. will not be held responsible for further disclosure of your information sent via unencrypted email.**

Client's signature: _____
For authorization of e-mail communications