

CLIENT INTAKE INFORMATION 2/2010
Please PRINT All Information clearly
(For relationship counseling, each party completes their own form)

Appointment Date _____ Therapist you will be seeing: _____

YOUR FULL NAME: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

e-mail address: _____ (Y / N) send newsletter

Date of Birth: ____/____/____ **Age:** ____ **Sex:** (M) ____ (F) ____

Home Phone # (____) _____ **cell or work #** (____) _____ **ext:** _____
Please indicate which number to use for appointment reminders

SS # ____--____--____ **Church Affiliation:** _____

Marital Status : (S)____ (En)____ (M)____ (How long : ____) How many times have you been married? ____.
 How many times has your spouse (or fiancé) been married? ____ (Div)____ (How long: ____)
 (Sep) ____ (How long : ____) (Wid.) ____ (How long : ____)

Family Members: (if married - include spouse)

Name	Age	D.O.B.	Relationship	Living At Home With You (✓)
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____

How were you referred to the Counseling Center? _____

In case of Emergency, the Therapist may contact: _____

Phone #: (____) _____ Relationship to Client: _____

Responsible party for this account / bill: _____
 Relationship to client: Self ____ Spouse ____ Parent ____ Priest EAP service ____

If responsible party is other than client or EAP - please ask for a release of information to sign.

Do you have **health insurance to cover your mental health counseling?** ____ Yes ____ No
 Do you want us to file insurance for you? _____

Insurance Company: _____ Phone # (____) _____

Insured Person _____ Ins. ID#: _____

Employer: _____ Auth. # if required: _____

Job experience / Skills: Current Employer: _____

Occupation: _____ Address: _____

City: _____ State: _____ Zip: _____

Working: ____ Full Time ____ Part Time ____ Student ____ Other _____

Description of the problem(s): The following is a list of areas in which you may be experiencing some difficulty. Please check (✓) any of the symptoms that apply to you or help to describe a problem you are having.

A. PHYSICAL CONCERNS

1. CHANGE IN:

- Sleep
- Appetite
- Physical Energy
- General Health
- Weight
- Interest in Activity

2. INCREASED USE OF:

- Alcohol
- Drugs
- Pain relievers
- Antacids
- Laxatives
- Diet pills
- Sleeping pills
- Other: _____

3. RECENT HISTORY OF:

- Nausea & Vomiting
- Diarrhea
- Fever, Chills, Sweats
- Chest pain
- Shortness of breath
- Palpitations (pounding heart)
- Rapid breathing
- Severe headache
- Head injury
- Loss of consciousness
- Loss of memory
- Change in vision
- Difficulty in speech
- Loss of balance
- Swollen joints

- Skin rash
- Miscarriage
- Abortion
- Seizure (s)
- Numbness
- Paralysis
- Dizziness
- Tingling
- Blackouts
- Delirium Tremors
- Flashbacks
- Illness
- Hospitalization
- Bleeding
- Infection

B: PSYCHOLOGICAL CONCERN

1. THOUGHTS OF:

- Suicide
- Harming self
- Harming others

2. EXPERIENCE OF:

- Vivid dreams or nightmares
- Decreased need for sleep
- Hearing voices
- Seeing visions
- Being out of body
- Thought control
- Racing thoughts

3. FEELINGS OF:

- Anxiety
- Depression
- Dread
- Despair/Hopelessness
- Low self worth
- Jealousy
- Tension
- Rage
- Persecution
- Boredom
- Loneliness
- Guilt
- High Energy

4. FEAR OF:

- Loss of control
- Death
- Being alone
- Objects
- Animals
- Places
- Situations
- Being possessed
- Being insane
- Cancer
- AIDS
- Exposure
- Punishment

C. SOCIAL - OCCUPATIONAL CONCERNS

1. CONFLICT WITH:

- Spouse
- Family member
- Child
- Friend / peer
- Work supervisor

2. PROBLEM WITH:

- Finances
- Legal authorities
- Job
- School

3. VICTIM OF:

- Bad accident
- Rape
- Physical abuse
- Sexual abuse
- Verbal abuse
- Violent crime
- Persecution
- Discrimination
- Disfigurement
- Vandalism

- Emotional abuse
- Spouse or child abuse
- Harassment
- War injury
- Natural disaster
- Witness to violence / death
- Cult group / practice
- Slander
- Malpractice

On the scale below, please estimate the severity of your problems:

Mild Moderate Severe Extreme Incapacitating

In your own words, state the nature of your problem(s)? What has been tried that has helped or tried and made things worse? (Use the back if more space is needed).

Job satisfaction: _____ Very High, _____ High, _____ OK, _____ Low, _____ None, _____ Minus

Job Status: (____) secure, (____) in jeopardy, (____) unemployed, (____) retired, (____) disabled,
(____) worker's comp., (____) social security, (____) working more than one job,
(____) other: _____

Other kinds of work I am qualified to do: _____

Highest level of completed education: _____ Elementary _____ Junior/Middle School
High School _____ College _____ Graduate School _____ Doctorate _____

Past Psychological Treatment:

Have you ever had previous therapy or been hospitalized for a nervous or mental disorder? Yes No

When? _____ For How Long? _____

Where? _____

Who was your Doctor? _____

Have you ever attempted suicide? No Yes

When? _____ How? _____

General Health: How would you rate your overall health?

Excellent Good Average Poor

Primary Care Physicians Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (____) _____ Date of last physical: _____

List ALL Medication being taken at this time: _____

Medical History (List problems, allergies & dates including surgeries): _____

EPISCOPAL COUNSELING CENTER POLICY STATEMENT

I understand that I am consenting to treatment or testing, have read the policy letter, and that my **records** will remain with the Episcopal Counseling Center.

I authorize the Episcopal Counseling Center to **release** any necessary information to expedite insurance claims if they are being filed on my behalf. I understand that it is customary to pay for professional services when they are rendered, that I am responsible for all charges, regardless of insurance coverage, and that my account may be turned over to a collection agency if payment is not made.

I also understand that unless I give a 24 hour notice to cancel an appointment, **I will be financially responsible for a charge of \$50** for a missed appointment (regardless of insurance coverage). There is a voicemail answering service (or machine) available to leave a message if the office is closed, and emergency situations can be discussed with my therapist.

The State of Florida requires that the Episcopal Counseling Center inform you that under the following circumstances, **confidentiality will be breached:**

- 1). When there is cause to suspect a child, adolescent, or elder has been or may be abused.
- 2). When there is reasonable cause to believe that you pose risk of imminent harm to yourself.
- 3). When there is reasonable cause to believe that you pose risk of imminent harm to another individual.
- 4). When there is a valid court order compelling records or witness testimony.

If supervision is required by a student therapist or registered intern therapist, client information will be released only to the supervisor and your therapist will inform you if that is the case.

A have read the HIPAA Notice of Privacy Practices located at www.ecc1021.com or have received a hard copy from the office. (Please ask for a copy, we are happy to give it to you).

I have read and understand all of the above.

(Client signature)

(Spouse or parent signature)
If needed

(Client **PRINTED** name)

(Date)