INTAKE FORM

NEW ____ UPDATED _____ **THERAPIST: _____**

Client Name: _____ Today's Date: _____

Responsible Party (if different than client) & Relationship: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ or _____ SSN: _____

Date of Birth: _____ Age: ____ Gender: ___Male ___Female ___Other

Emergency contact and phone number: _____

Health Insurance Provider: _____

Who referred you to Wilson Counseling? _____

**** SIGNATURES ARE REQUIRED IN ORDER TO PROVIDE SERVICES AND IN ORDER TO BILL INSURANCE!****

ASSIGNMENT OF BENEFITS: I request payment of private insurance and/or government benefits for my treatment be made to Wilson Counseling, LLC.

_____ _____

Signature of Client/Authorized Representative/Guardian Date

PRACTICE POLICIES AGREEMENT: I have provided a copy of and read the Notice of Practice Policies and agree to the terms therein.

_____ _____

Signature of Client/Authorized Representative/Guardian Date

PERMISSION TO TREAT: I, for myself and/or as legal guardian for _____, understand that I and/or my child will be taking part in mental health services which are psychological in nature. I have received a copy of the Notice of Privacy Practice and Informed Consent and hereby give permission for Wilson Counseling to provide services.

_____ _____ Signature

of Client/Parent/Guardian Date

CLIENT NAME: _____

Joint Custody Permission to Treat

I, as JOINT CUSTODIAL PARENT of _____, hereby give permission for the above-named child to receive and participate in counseling/mental health services with Wilson Counseling, LLC. I understand that requirement of consent from both custodial parents is required for treatment of services to be provided. I understand that both custodial parents will be provided opportunity to participate in treatment planning and, when appropriate and recommended by the treating clinician, participate in therapy sessions. I understand that the child is the identified client and billing will be made through insurance coverage on that child for client and/or family sessions. I understand that Dr. Smith may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at her sole discretion. Dr. Smith may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court or counsel for my child.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

FOSTER PARENT/PRIVATE CHILD CARE REPRESENTATIVE CONSENTS

The above-named child is in State custody. As the currently assigned case worker am the representative guardian, I hereby give permission for the above-named child's foster parent or Private Child Care (PCC) representative (therapist, case manager or foster parent) to provide information and sign necessary intake, history, treatment plans, physician communication forms, and health insurance documentation as required by Wilson Counseling, LLC. Copies of all signed documents shall be maintained in the client's file.

___ I hereby give permission for the above-named child's PCC representative to sign a Release of Information on behalf of the child for information to be provided to the Court, attorneys and/or other persons participating in the care of the client as part of wrap-around services and as specifically requested.

_____ _____

Authorized Representative Date

PRINTED NAME OF AGENCY: _____

PRINTED REPRESENTATIVE NAME & TITLE: _____

WILSON COUNSELING, LLC

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

When we evaluate, diagnose, treat and/or refer you or the person you represent, we will be collecting what the law calls Protected Health Information (PHI) about you. We need the information to decide what treatment is best for you and to provide that treatment. The Notice of Privacy Practices (NPP) that was given to you explains in more detail your rights and how we can use and share your information as regulated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information. We may share your PHI with others who provide treatment to you, who need it to arrange payment for your treatment, or for administrative purposes. In other situations, we can release information about your treatment only if you sign a written authorization form. Please read the Notice of Privacy Practices carefully. If you have any questions, we will try to answer them.

If you have a concern about the use of your information, you have the right to ask us to restrict how we use or share your information for treatment, payment or administrative purposes. You will have to tell us in writing what you want. Although we will try to respect your wishes, we are not required to agree to the limitations you request.

After you have signed this consent, you have the right to revoke it in writing and we will comply with your wishes about using or sharing your information from that time on, but we may have already used or shared some of your information which cannot be changed after the fact.

By signing below, you are affirming that you have received a copy of our NPP, read our NPP and you are consenting to let us use your information here and send it to others as needed for your treatment.

_____ _____

Signature of Client/Parent/Personal Representative Date

_____ _____

Printed Name of Client/Parent/Personal Representative Relationship to Client

Client Email/Texting Informed Consent Form

A. Risk of using email/texting. The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Email and texts can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

B. Conditions for the use of email and texts. Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. Email and texts will usually be printed and filed into the client's medical record.
4. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
7. It is the client/guardian's responsibility to follow up and/or schedule an appointment if warranted.

C. Client Acknowledgement and Agreement. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

CLIENT NAME: _____

_____ _____

Signature of Client/Parent/Personal Representative Date

_____ _____

Printed Name of Client/Parent/Personal Representative Relationship to Client

Assessment requested by: ___ Self ___ Court ___ Attorney ___ DCBS ___ Other

Please give brief description of problem. _____

_____

_____

_____

_____

_____

Length of problem: _____ mos/yrs Problem severity: ___ Serious ___ Moderate ___ Minor

Please check current or recent symptoms:

- ☐ Abuse (physical)
- ☐ Abuse (sexual)
- ☐ Abuse (emotional)
- ☐ Anxiety
- ☐ Depressed mood
- ☐ Dislike self
- ☐ Divorce/separation
- ☐ Eating problem
- ☐ Excessive anger
- ☐ Excessive Energy
- ☐ Financial stress
- ☐ Focus problems
- ☐ Grief
- ☐ Hallucinations
- ☐ Impulsive behaviors
- ☐ Irritability
- ☐ Loss of interest
- ☐ Memory problems
- ☐ Oppositional or disrespectful
- ☐ Overreact often
- ☐ Panic symptoms
- ☐ Relationship problems
- ☐ Self-harm thoughts
- ☐ Sleep problems
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Worry a lot

Previous Mental Health Services

Name of Provider Inpatient/Outpatient Year Reason/Diagnosis

_____

_____

Please list persons who live with you.

Name Relationship Age How you get along

_____

_____

_____

_____

Please list supportive persons in your life (friends or family).

Name Relationship Age How you get along

_____

_____

_____

If your parents separated or divorced, how old were you? _____

Did you have any problems during early childhood or infancy? _____

How would you describe your childhood? Very pleasant Pleasant Difficult Very difficult

CLIENT NAME: _____

Family history of mental health issues

	None	Depression	Anxiety	Alcohol/Drugs	Other
Father					
Mother					
Brothers/Sisters					
Father's Family					
Mother's Family					

Health – Please circle conditions you have experienced.

AIDS	Diabetes	Liver Disease	None
Allergies	Headaches	Seizures	Other _____
Asthma	Heart Disease	STD	_____
Cancer	Hospitalization	Tics	_____

Please list all medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Who prescribes the medication? _____

Cultural Preferences

Faith-based beliefs: _____ Ethnicity: _____

Educational History

Are you currently a student? Yes No School _____ Grade ____

Did you have: ___ Learning difficulties ___ Behavior problems at school

How much do you enjoy school? ___ A lot ___ Some ___ Little ___ None

Work History

Are you currently employed? If yes, where? _____ How long? _____

How much do you like your job? A lot Some A little Not at all

Alcohol/Substances

Alcohol use: ___ Several drinks daily ___ Several drinks weekly ___ A few drinks a month) ___ None

Substance use: ___ Currently use ___ Used in Past ___ Never used

Legal History

Do you have an active court case? Yes No Court/Judge_____

Do you have another court date? If yes, when? _____

Do you have an open DCBS case? Yes No If yes, worker: _____

Social History

How many friends do you have? ___ None ___ Few ___ Some ___ Many ___ A lot

What are your interests or hobbies? _____

What are your strengths or things you like about yourself? _____

What are things you want to change about yourself? _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS TRUE AND FACTUAL.

_____ _____

CLIENT SIGNATURE Date

END OF INTAKE QUESTIONNAIRE

****

FOR CLINICIAN USE ONLY:

DIAGNOSES:

1. _____
2. _____
3. _____
4. _____

Notes: _____
_____
_____
_____

_____ _____

CLINICIAN SIGNATURE & CREDENTIALS Date