Wilson Counseling
LIFE CAN BE GOOD

INTAKE FORM

INTAKE PACKET

NEW _____ UPDATED _____ **THERAPIST: _____**

Client Name: _____ Today's Date:_____

Responsible Party (if different) & 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/Wilson Place? _____

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

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

   _____ _____
   Signature of Parent/Guardian Date

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

   _____ _____
   Signature of Parent/Guardian Date

3. **PERMISSION TO TREAT FOR MYSELF:** I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services.

   _____ _____
   Signature of Parent/Guardian Date

4. **PERMISSION TO TREAT FOR MY CHILD:** I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services. I understand that consent from both custodial parents is required for treatment 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 the decision to meet with me, my attorney, any other party or other attorney in any custodial or divorce proceeding is at sole discretion of the clinician.

   _____ By initialing here, I affirm that I have sole custody of my child.

   _____ _____
   Signature of Parent 1 Date

   _____ _____
   Signature of Parent 2 Date

5. **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.

   _____ _____
   Signature of Parent 1 Date

   _____ _____
   Signature of Parent 2 Date

6. **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. 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. 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.

   _____ _____
   Signature of Parent/Guardian Date

CLIENT NAME:_____

7. **SESSION RECORDING POLICY:** Therapy sessions shall not be recorded in any fashion without express agreement and permission of both client and clinician. By signing below, client understands that any session recorded without permission shall obligate client to provide clinician with written transcript of session prepared by a neutral party. Said transcript shall be signed and notarized as true and correct. Cost of any transcription shall be sole responsibility of client. Client is encouraged to maintain handwritten notes of pertinent points from sessions to provide opportunity for later review to assist in reaching therapeutic goals.

_____ _____

Signature of Parent/Guardian Date

8. **LIENT TEXTING/EMAIL CONSENT:** The transmission of client information by email and/or texting has several 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 easily 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 his or her copy. 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. 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. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Therapist is not liable for breaches caused by third party. Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.

_____ _____

Signature of Parent/Guardian Date

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

Please give brief description of problem.

_____

_____

_____

_____

_____

_____

Length of problem: _____ (months/years) Problem severity: ____Serious ____Moderate ____Minor

CLIENT NAME:_____

Please check current or recent symptoms:

- O Abuse (physical)
- O Abuse (sexual)
- O Abuse (emotional)
- O Anxiety
- O Depressed mood
- O Dislike self
- O Divorce/separation
- O Eating Problem
- O Excessive Anger
- O Focus problems
- O Grief
- O Hallucinations
- O Impulsive behavior
- O Irritability
- O Loss of interest
- O Memory problems
- O Excessive energy
- O Financial Stress
- O Panic Symptoms
- O Overreact often
- O Opposition or disrespectful
- O Relationship Problems
- O Self-harm thoughts
- O Sleep Problems
- O Suicidal Thoughts
- O Suspiciousness

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					
Siblings					
Father's Family					
Mother's Family					

Health (Please circle conditions you have experienced)

AIDS	Seizures	Tics
Diabetes	Allergies	STD's
Liver Disease	Hospitalization	None
Headaches	Asthma	Other_____
Heart Disease	Cancer	Other_____

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

CLIENT NAME:_____

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

****

CLIENT NAME:_____

FOR CLINICIAN USE ONLY:

DIAGNOSES:

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

Notes:_____

_____

_____

_____

_____

_____

_____

_____ _____

Clinician Signature & Credentials **Date**