COUNSELING INTAKE FORM

Confidential

DEMOGRAPHIC INFORMATION

Name: ____________________ Date: ____________

Birth Date / Place: ____________________ Relationship Status: ____________

Mailing Address: ____________________

Email Address: ____________________ May we email you? ❑ Yes ❑ No

Phone Number: ____________________ May we text message? ❑ Yes ❑ No

Referred by: ____________________

Emergency Contact: ____________________ Contact Phone: ____________

Employer: ____________________ Work Phone: ____________

Please list any children and ages: ____________________

____

Highest Grade/Degree: ____________________ Type of Degree: ____________

CURRENT CONCERNS

Reason for seeking counseling: ____________________

When did this begin? (Give dates.) ____________________

What do you hope to accomplish in counseling? ____________________

____

BEHAVIOR (CHECK ANY THAT APPLY)

- ❑ Overeating
- ❑ Temper outbursts
- ❑ Aggressive behavior
- ❑ Phobic avoidance
- ❑ Work too hard
- ❑ Concentration difficulties
- ❑ Sleeping problems
- ❑ Can't keep a job
- ❑ Loss of control
- ❑ Lack of motivation
- ❑ Withdrawal
- ❑ Suicidal thoughts
- ❑ Drink too much
- ❑ Impulsive reactions
- ❑ Crying
- ❑ Take drugs
- ❑ Take too many risks
- ❑ Procrastination
- ❑ Compulsions
- ❑ Smoking
- ❑ Vomiting
- ❑ Nervous Tics

FEELINGS (CHECK ANY THAT APPLY)

- ❑ Unhappy
- ❑ Angry
- ❑ Regretful
- ❑ Fearful
- ❑ Optimistic
- ❑ Jealous
- ❑ Depressed
- ❑ Conflicted
- ❑ Lonely
- ❑ Hopeful
- ❑ Energetic
- ❑ Happy
- ❑ Sad
- ❑ Anxious
- ❑ Excited
- ❑ Relaxed
- ❑ Annoyed
- ❑ Guilty
- ❑ Hopeless
- ❑ Panicky
- ❑ Tense
- ❑ Bored
- ❑ Restless
- ❑ Contented
- ❑ Helpless
- ❑ Envious
- ❑ Others:

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PHYSICAL (CHECK ANY THAT APPLY)

- ❑ Stomach trouble
- ❑ Watery eyes
- ❑ Hear things
- ❑ Fainting spells
- ❑ Sexual disturbances
- ❑ Dizziness
- ❑ Headaches
- ❑ Numbness
- ❑ Excessive sweating
- ❑ Blackouts
- ❑ Fatigue
- ❑ Tics
- ❑ Skin problems
- ❑ Hearing problems
- ❑ Tingling
- ❑ Tension
- ❑ Burning/Itching Skin
- ❑ Dry mouth
- ❑ Muscle spasms
- ❑ Visual Disturbances
- ❑ Tremors
- ❑ Back pain
- ❑ Twitches
- ❑ Palpitations
- ❑ Other: ____________________
- ❑ Bowel disturbances
- ❑ Unable to relax
- ❑ Rapid heart beat
- ❑ Chest pains

How would you rate your current physical health?
❑ Poor ❑ Unsatisfactory ❑ Satisfactory ❑ Good ❑ Very Good

Are you currently experiencing any chronic pain? ❑ Yes ❑ No

If yes, please describe: ____________________

How often do you drink alcohol?
❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

How often do you engage in recreational drug use?
❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

Are you currently in a romantic relationship? ❑ Yes ❑ No If yes, how long? ____________________

What significant life changes or stressful events have you experienced recently? ____________________

____

____

Have you received psychological, psychiatric, or counseling services in the past? ❑ Yes ❑ No

If yes, what was your concern at the time? ____________________

If yes, with whom and what was the result? ____________________

List any psychiatric medications you may have been prescribed: ____________________

____

FAMILY MEDICAL HISTORY (CHECK ANY THAT APPLY)

- ❑ Alcohol/Substance abuse
- ❑ Domestic violence
- ❑ Obsessive Compulsive
- ❑ Anxiety
- ❑ Suicidality
- ❑ Relational issues
- ❑ Depression
- ❑ Temper
- ❑ Child abuse
- ❑ Bi-polar

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SOCIAL LIFE

Do you have trusted friends with whom you can share your concerns? ______________________________

What are your hobbies/interests? ______________________________

____

____

How would you describe your relationship with your family? ______________________________

____

____

What is your involvement in the community? (E.g., volunteering, church, schools, etc.) ______________________________

____

____

How would you describe your spiritual life? ______________________________

____

____

Are you involved in any current or pending civil or criminal litigation(s), lawsuit(s), or divorce/custody disputes? If yes, please explain:

____

____

____

What are your main worries and fears? ______________________________

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____

What are your most important hopes and dreams for your future? ______________________________

____

____

What gives you the most happiness or pleasure in life? ______________________________

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CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the Client Information packet and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Edwin Molina MS, LPC, NCC. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided in therapy.

I am aware that I may stop my treatment at any time. I will be responsible for paying for any services I have already. I understand that I may lose other services or may have to deal with other concerns if I stop treatment. (For example, if my treatment has been court-ordered, I will answer to the court).

I know that I must call, email, or send a text message to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up for the scheduled appointment, I will be charged the full session fee.

I am aware, that if I choose to use my insurance provider, or other third-party payer, an agent the insurance company may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all these statements.

____

Signature of Client (or person acting for client) *Date*

____

Printed name *Relation to client (if necessary)*

I, Edwin Molina MS, LPC, NCC, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Edwin Molina MS, LPC, NCC *Date*

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care serves to you, to pay your health care bills, to support the operation of the physician's practice, and by any other use required by law. Treatment: We use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from insurance companies. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization:

- If you are determined to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- If you disclose sexual misconduct by a mental health professional.
- To qualified personnel for certain kinds of audits or evaluations.
- In a criminal court proceeding.
- In legal or regulatory actions against a professional.
- In proceedings in which a claim is made about one's physical, emotional, or mental condition.
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations.
- Where otherwise legally required.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may request that any part of your protected health information not be disclosed for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction with you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from this office, upon request.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by your notification and we will not retaliate against you for filing a complaint. If you have objections to his form, please contact Edwin Molina MS, LPC, NCC at (713) 954-4872.
I have read the notice listed above.

____

Signature of Client (Client's Parent/Guardian if under 18 years old) *Date*

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COUNSELOR LIMITS OF CONFIDENTIALITY

Your counselor recognizes that confidentiality is essential to effective counseling. In order for counseling to work best, you must feel safe about sharing your personal information with your counselor. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- If you disclose sexual misconduct by a mental health professional.
- To qualified personnel for certain kinds of audits or evaluations.
- In a criminal court proceeding.
- In legal or regulatory actions against a professional.
- In proceedings in which a claim is made about one's physical, emotional, or mental condition.
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations.
- Where otherwise legally required.
- Insurance providers and other third-party payer are given information that they request regarding services to clients.

A court may not consider information that you also share, outside if counseling, willingly and publicly, protected or confidential. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with you counselor. You may also contact: www.dshs.state.tx.us/counselor/default.shtm.

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

____

Signature of Client (Client's Parent/Guardian if under 18 years old) *Date*

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AUTHORIZATION FOR CREDIT CARD USE

Please fill in the information and sign below to authorize
automatic payment by credit card after each session.

Print Name: ______________________________

Phone Number: ______________________________

Email: ______________________________

Credit Card Type: ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

Credit Card Number: ______________________________

Security Code: ______________ Expiration Date: ______ / _______

Name as it appears on card: ______________________________

Billing Address: ______________________________

City: ______________________ State: ________ ZIP: _________

Card Holder Phone Number: ______________________________

I authorize **Molina Counseling & Consulting** to initiate an initial charge of $ __________ following my first session, followed by a recurring charge of $ __________ after each subsequent session to the credit card indicated above for the total amount due after each therapy session. I will be provided notice if the charges exceed $ ___________.

I understand I may cancel my recurring charge at any time upon written notice to:

Molina Couseling & Consulting
2500 Wilcrest Drive, Suite 300
Houston, TX 77042

____

Card Holder Name (Printed)

____

Card Holder Signature *Date*