PERMISSIONS AND CONSENTS

See **FOR YOUR RECORDS** form for corresponding information

1.ASSIGNMENT OF BENEFITS (All clients **MUST** sign)

____ _________________

Signature of Client or Guardian Date

2.PRACTICE POLICIES AGREEMENT (All clients **MUST** sign)

____ _________________

Signature of Client or Guardian Date

3.PERMISSION TO TREAT FOR MYSELF (ADULT)

____ _________________

Signature of Client or Guardian Date

4.CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION (All clients **MUST** sign)

____ _________________

Date

Signature of Client or Guardian

5.SESSION RECORDING POLICY (All clients **MUST** sign)

____ _________________

Signature of Client or Guardian Date

6.CLIENT TEXTING/EMAIL CONSENT (All clients **MUST** sign)

____ _________________

Signature of Client or Guardian Date

7.PERMISSION TO TREAT FOR MY CHILD. IF JOINT CUSTODY BOTH PARENTS MUST SIGN!

____ _________________

Signature of Parent 1 Date

____ _________________

Signature of Parent 2 Date

8. PERMISSION TO TREAT VIA TELEHEALTH (All clients **MUST** sign)

____ _________________

Signature of Client or Guardian Date

Client Name:_________________________

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? ____

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

Please give brief description of problem.

____

____

____

____

____

____

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

Please check current or recent symptoms:

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

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 or check 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? Yes No Behavior problems at school? Yes No

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

Work History

Are you currently employed? Yes No 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? Yes No 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? ____

CLIENT NAME:_____________________________________