

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)

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

FEELINGS (CHECK ANY THAT APPLY)

- | | | | | |
|-------------------------------------|-------------------------------------|----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Unhappy | <input type="checkbox"/> Depressed | <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Helpless |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Conflicted | <input type="checkbox"/> Anxious | <input type="checkbox"/> Panicky | <input type="checkbox"/> Envious |
| <input type="checkbox"/> Regretful | <input type="checkbox"/> Lonely | <input type="checkbox"/> Excited | <input type="checkbox"/> Tense | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Bored | _____ |
| <input type="checkbox"/> Optimistic | <input type="checkbox"/> Energetic | <input type="checkbox"/> Annoyed | <input type="checkbox"/> Restless | _____ |
| <input type="checkbox"/> Jealous | <input type="checkbox"/> Happy | <input type="checkbox"/> Guilty | <input type="checkbox"/> Contented | _____ |

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

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? _____

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

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

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 Destiny “Desi” Teague, MA, LPC. 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, Destiny “Desi” Teague, MA, LPC, 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.

Destiny “Desi” Teague, MA, LPC

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 services 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 Destiny “Desi” Teague, MA, LPC at (832) 529-6172. I have read the notice listed above.

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

Date

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 of 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 your 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

Forms of payment accepted: Credit/Debit Card, Cash or Venmo

AUTHORIZATION FOR CREDIT CARD USE

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

Print Name: _____
Phone Number: _____
Email: _____
Credit Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> 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 **Destiny “Desi” Teague, MA, LPC** to charge the credit card indicated above for each therapy session.

Card Holder Name (Printed)

Card Holder Signature *Date*