Mind Body Soul Integrative Clinic
Counseling Intake Forms

Confidential Client History

Date _____

Name _____

Address _____

Phone _____

Email _____

Date of Birth _____ Age _____

Male ( ) Female ( ) Marital Status _____

Religious/Spiritual Orientation _____

Employment/Occupation_____

Highest Level of Education Completed _____

Phone for Emergency Contact (list relationship, ie, spouse)
_____

Please describe why you are seeking help at this time:
_____
_____
_____
_____
_____
_____
_____
_____

Informed Consent for Assessment and Treatment

Welcome to the counseling practice. A counseling situation offers a unique relationship between client(s) and therapist. In order that we start our relationship in a healthy way, we have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs or desires in therapy are not a good match for my skills or experience.

FINANCIAL

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED

By signing this document, you are agreeing to pay for the services rendered. The current fee for a 50 minute individual counseling session is $135. plus gst. , or a 70 minute family or couples session is $150. plus gst.

APPOINTMENTS

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an hour or more for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel.

Privacy, confidentiality, and records. Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved.

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more

often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

During the course of treatment, we will draw on various psychological approaches according, in part, to the problem that is being treated and our assessment of what will best benefit you. These approaches include behavioral, cognitive behavioral, family systems, developmental (adult, child, family), psycho educational, and spiritual prayer and direction when requested.

TREATMENT PROCESS AND RIGHTS

Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and together develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

OUR RELATIONSHIP:

The client/counselor relationship is unique in that it is exclusively therapeutic.
If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

TERMINATION:

You have the right to terminate therapy at any time. If you request it and authorize it in writing, we will make referrals and assist with the transition to a new therapist.

Consent for evaluation and treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent form. I acknowledge that I have received a copy of this informed consent agreement It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided.

Signature:_____ Date:_____

Prayer Option:

I desire the use of prayer as part of my counseling. ____yes ____no

Family Information

People Currently Living in your Household
Name Age Relationship

_____
_____
_____
_____
_____
_____

Original Family Members (parents, siblings, etc)
Name Age Relationship

_____
_____
_____
_____
_____

Parents' marital status:_____ Where do they live? _____
Client place of birth: _____

Marital History and Other Relationships

Please list the following information regarding current marriage and any divorces Date Married _____

Date Separated or Divorced _____

Reason for Separation or Divorce

_____
_____

Blended Family Arrangements
Child Name and Age: _____

Relation to you/ custody arrangement when in your household:

_____
_____

_____

Child Name and Age: _____
_____
__ _____

Relation to you / Custody arrangement when in your household
_____
_____
_____

What is a strength of your current marital/partner relationship?
What is a weakness of your current marital/partner relationship?
What is the one main thing you would like to see different in your relationship?

If divorced, what did you learn about yourself through the(se) process(es)?

What if any relationships do you have that are not going well at this time?
_____

What if any relationships do you have that are supportive and fulfilling
_____

Family Mental Health History

Has any family member been hospitalized for mental health concerns? _____

If yes, please list who, when, and for what reason
_____
_____
_____

Do/did any family member have/had a problem with drinking alcohol or using drugs?
_____
_____

If yes, please list who, when, and for what reason
_____
_____
_____
_____
_____

Have any family members killed themselves or try to kill themselves? _____ If yes, please list who, when, and what happened _____

Personal Health/Mental Health Information

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug or alcohol concerns? _____

If yes, please list who, when, and why _____
_____
_____

Have you ever been hospitalized for any mental health concerns? _____

If yes, please list where, when, and why _____
_____
_____

Do you currently have thoughts of killing yourself? _____ If yes, how often do you have these thoughts? _____
Have you ever tried to kill yourself? _____

If yes, when was this? _____

Did you receive medical help? _____
If yes, what kind of medical intervention?
_____

Please check any of the following that you have experienced:
( ) Head Injury ( ) Loss of Consciousness ( ) Seizures ( ) Convulsions
If yes, please explain _____
_____

_____
_____

Have you ever had surgery? _____ If yes, please explain when, where, why, and type
_____
_____

Please list any **CURRENT** health concerns
_____
_____
_____
_____

Please list any **PAST** serious illnesses or health concerns_____
_____

Current Medications:
_____
_____
_____

Chemical usage

Do you drink alcohol? _____
If yes, how much, how often? _____
Have you ever been treated for alcoholism?_____
Attended A.A.? _____Where and when?_____
At what age did you start drinking?_____
Do you use drugs? _____
What drugs have you used? _____
At what age did you start using drugs? _____
Have you ever been treated for drug abuse? _____
Where and when?_____
Are you in recovery for chemical dependence? _____
Is there any family history of addictions?
_____
_____

Financial

If you currently have financial problems, please describe them

_____
_____
_____
_____

Legal History

Have you ever been arrested? (Dates and reasons for each)

_____
_____

Have you ever been incarcerated or placed on probation?_____
_____

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

( ) Chronic sadness ( ) Low frustration tolerance
( ) Crying episodes ( ) Irritability

( ) Hopelessness ( ) Sleep problems
( ) Difficulty concentrating ( ) Memory problems

( ) Loss of appetite ( ) Thoughts of suicide
( ) Overeating ( ) Withdrawing from others
( ) Nausea/Vomiting ( ) Difficulty functioning at work
( ) Difficulty making decisions ( ) Difficulty functioning socially
( ) Low energy/fatigue ( ) Reduced pleasure in activities
( ) Agitation ( ) Panic attacks
( ) Restlessness ( ) Fear of leaving home
( ) Excessive worry ( ) Avoidance of public places
( ) Fearfulness ( ) Avoidance of social situations
( ) Trembling/shaking ( ) Pounding heart/palpitations
( ) Fear of loss of control ( ) Shortness of breath
( ) Fear of dying ( ) Feeling detached from others/life
( ) Intrusive thoughts of bad memories ( ) Nightmares
( ) Flashbacks/reliving bad experiences ( ) Easily startled/upset
( ) Hear voices others do not hear ( ) Seeing things others do not see
( ) Fearful others are talking about me ( ) Tried to kill myself

( ) Difficulty completing tasks/distracted ( ) Taking on too many tasks ( ) Difficulty focusing ( ) Frequent forgetfulness ( )
( ) Tendency to act impulsively ( ) Difficult to wait my turn
( ) Not well organized ( ) Problems with co-workers
( ) Legal Problems ( ) Problems in school growing up
( ) Difficulty at work ( ) Hard to stay with a job very long
( ) Racing thoughts ( ) Marital Conflict
( ) Excessive spending ( ) Multiple sexual partners
( ) Excessive gambling ( ) Marital Violence
( ) Aggressive/abusive toward others ( ) Worried about sexual behavior ( ) Thoughts of physically hurting others
( ) Staying up for days without sleep