



CLIENT INTAKE PACKET

A thorough assessment is important because it can provide your counselor with helpful information about your background and because most insurance policies and other third party payers require that counselors collect this information. In an effort to ensure that our counselors can spend time in-session focusing on what is most important to you instead of collecting this information, we ask that you complete this packet and bring it with you to your first appointment.

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work #: _____ Cell #: _____

Email Address: _____

Social Security Number: _____ DOB: _____ Age: _____

May we...

Leave messages at the above phone numbers? YES NO

Send appointment reminders via text message to the above cell number? YES NO

Send appointment reminders to the above email address? YES NO

Contact you via email if we cannot reach you by phone? YES NO

File claims with your insurance company or other payer? YES NO

Name and Number of Emergency Contact Person: _____

How did you hear about Integrity Counseling? _____

Briefly describe the issues/problems that led you to counseling today:

What goals would you like to achieve with counseling? _____



INTEGRITY COUNSELING, INC. POLICIES AND CONSENT TO TREATMENT

FINANCIAL POLICY Full payment is due at time of service (unless prior arrangements have been made). Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. Insurance is a contract between you and your insurance company. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e. diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice. Uncollected balances may be turned over for collection or reported to the state's attorney's office.

CANCELLATION POLICY Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so we can offer that time to someone else. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal counseling session. This will be billed to you. We may require prepayment in order to schedule a subsequent appointment.

CONFIDENTIALITY Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Integrity Counseling, Inc. without your written permission, except as required by law or as needed to file your insurance claim. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breaching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

CONSENT TO TREATMENT I am voluntarily seeking outpatient counseling at Integrity Counseling & Coaching. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at Integrity.

Individual counseling sessions are intended to be 45-52 minutes in length.

Please note: We do not provide emergency services. In true crisis call 911.

With my signature, I acknowledge that I understand the above information and consent to treatment at Integrity Counseling, Inc.

Client's Signature (if printing this document): _____

Electronic Signature (If typing this document, check this box to affix electronic signature):

Client's Printed Name: _____

Parent/Guardian's Signature (if printing this document): _____

Electronic Signature (If typing this document, check this box to affix electronic signature):

Parent's/Guardian's Printed Name: _____

CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.”

- | | |
|--|---|
| <input type="checkbox"/> I have no problem or concern bringing me here. | <input type="checkbox"/> Headaches, other kinds of pains |
| <input type="checkbox"/> Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals | <input type="checkbox"/> Health, illness, medical concerns, physical problems |
| <input type="checkbox"/> Aggression, violence | <input type="checkbox"/> Housework/chores—quality, schedules, sharing duties |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Inferiority feelings |
| <input type="checkbox"/> Anger, hostility, arguing, irritability | <input type="checkbox"/> Interpersonal conflicts |
| <input type="checkbox"/> Anxiety, nervousness | <input type="checkbox"/> Impulsiveness, loss of control, outbursts |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Career concerns, goals, and choices | <input type="checkbox"/> Judgment problems, risk taking |
| <input type="checkbox"/> Childhood issues (your own childhood) | <input type="checkbox"/> Legal matters, charges, suits |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Custody of children | <input type="checkbox"/> Menstrual problems, PMS, menopause |
| <input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Motivation, laziness |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Nervousness, tension |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves) |
| <input type="checkbox"/> Divorce, separation | <input type="checkbox"/> Oversensitivity to rejection |
| <input type="checkbox"/> Drug use—prescription medications, over-the-counter medications, street drugs | <input type="checkbox"/> Panic or anxiety attacks |
| <input type="checkbox"/> Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”) | <input type="checkbox"/> Parenting, child management, single parenthood |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Pessimism |
| <input type="checkbox"/> Fatigue, tiredness, low energy | <input type="checkbox"/> Procrastination, work inhibitions, laziness |
| <input type="checkbox"/> Fears, phobias | <input type="checkbox"/> Relationship problems (with friends, with relatives, or at work) |
| <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income | <input type="checkbox"/> School problems (see also “Career concerns”) |
| <input type="checkbox"/> Friendships | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce | <input type="checkbox"/> Self-neglect, poor self-care |
| <input type="checkbox"/> Guilt | |

- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

Which of the above concerns do you most want help with?

PSYCHOSOCIAL HISTORY

Treatment History

Have you ever participated in counseling, psychotherapy, psychiatric/mental health treatment, or substance abuse treatment? If so, please complete the following information to the best of your ability:

Date(s)	Provider	Purpose/Focus of Treatment	Outcome
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>



Trauma History

Did you experience any physical, sexual, or emotional/psychological abuse or neglect during childhood? If so, please describe:

Have you had any experiences you'd consider to be traumatic (e.g., threat of serious harm/injury, natural disaster, victim of a crime, traumatic losses/deaths, etc.)? If so, please describe:

Family Psychiatric History

Has anyone in your family ever been diagnosed or treated for a mental health disorder or for an alcohol- or drug-related problem? Has anyone had these problems but not been treated? If either apply, please indicate below:

<u>Family Member</u>	<u>Problem/Disorder</u>	<u>Describe Treatment (if any)</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>



Medical Conditions & History

Do you have any current or recent medical/physical concerns?

No Yes; Describe: _____

Do you have a primary care physician?

No

Yes; Name of Physician/Practice: _____

Do you have health insurance? Yes No

Please describe any history of surgeries, significant medical procedures, or ER visits, or major illnesses (including dates if possible):

Medications (including dosages, prescribing physician, and purpose of medication):

Allergies: _____



Substance Use

Please enter the following information for any substances including alcohol, tobacco, and drugs that you currently use or have used in the past:

Substance	Past Use? (Yes/No)	Current Use? (Yes/No)	How often/how much in past year?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Were you adopted? Yes No

Who lived with you growing up? _____

Did you have brothers or sisters? Yes No

If so, list their names and ages: _____

Did/do you have stepparents? Yes No

How would you describe your family growing up? _____

Did/do you have stepparents? Yes No

What was your parents' relationship with each other like? _____

What was your relationship with your mother like growing up? _____



What is your relationship with her like now (if living)? _____

What was your relationship with your father like growing up? _____

What is your relationship with him like now (if living)? _____

Did you experience any physical, emotional, or sexual abuse or neglect as a child or as an adult?

No Yes Describe: _____

What is your relationship status (check all that apply)? Single Married Dating

Co-habiting Divorced Separated Other: _____

Do you have children? No Yes Names and ages: _____

Social, Spiritual, & Developmental History

Where were you born? _____

Where did you live growing up? _____

Were there any complications with your birth? _____

Were there any developmental delays growing up? _____

Do you have history of any traumatic experiences (e.g., victim of crime, survivor of natural disasters, witness violence/death, loss of loved ones, etc.)? No Yes

If so, please describe: _____



What were your friendships like growing up? _____

Describe your friendships now: _____

Who do you turn to for support? _____

How many serious relationships have you been in your life? _____

Describe your history of romantic relationships: _____

Are you in a relationship now? Yes No If so, for how long? _____

Describe your relationship with your significant other: _____

Describe your sexual orientation: Heterosexual Homosexual Bisexual

Pansexual Questioning Asexual Other: _____

Describe your religious or spiritual beliefs: _____

Describe any social groups or institutions you are involved in (e.g., clubs, associations, congregations):

What do you do in your spare time? _____

Educational and Vocational History

What was school like for you growing up? _____

What is the highest level of education/highest grade you completed? _____

If you went to college or grade school, what degrees or certifications did you earn?

Describe your employment history: _____

Are you working now? Yes No

What is your occupation? _____ Annual income? _____

Describe any vocational/occupational goals you may have for the future: _____

Legal History

Have you ever been arrested? Yes No

If so, when and what charge(s)? _____

Describe any current legal concerns: _____

Other Information

What are your strengths? _____

Anything else you want us to know? _____