Intake —Adult

Please complete this form in its entirety.

PRESENTING PROBLEM

1) Please describe what brings you in today? _____
2) How long have you been experiencing this problem? (Less than 30 days) (1-3 months) Other _____
3) Rate the intensity of the problem 1 to 5 (l being mild and 5 being severe): (1) (2) (3) (4) (5)
4) How is the problem interfering with your day-to-day functioning? _____
5) How do you think we can best help you today? _____
6) Are you currently or in the last 30 days experienced any of the following symptoms? (circle all that apply)

Sadness Easily startled No motivation No appetite Hopeless/helpless Impulsive Can't sleep

Lack of interest in daily activities Talk too fast Hearing things Avoidance Feeling Nervous Sleep too much

Thoughts of dying Irritable/angry Fearful Seeing things not there Re-occurring Nightmares Fatigue/No energy

Panic attacks Guilt Shame Can't concentrate Feel worthless Restless/can't sit still No Need for sleep

Other: _____

MENTAL HEALTH

1) Have you received mental health services in the past? Yes No
2) If yes, whom did you see and when? _____
3) Is there a family history of mental health problems that you are aware of? Yes No Unsure
4) If yes, please describe: _____

MENTAL HEALTH CONT.

5) Have you ever been in the hospital for treatment of mental health? Yes No
6) Are you currently on any prescribed medications for mental health? Yes No
7) If yes, or if you've been prescribed medication for mental health in the past, please fill out the chart below:

Name of medication (prescribed, herbal or over the counter)	Dosage/how much?	Why was it prescribed?	Is this a current medication or past medication?	Length of time on medication?

PHYSICAL HEALTH

1) Do you have a primary healthcare provider? Yes No If yes, who? _____
2) Are you pregnant now? Yes No NA If yes, when are you due? (day/month/year) _____
3) Are you at risk for HIV/Sexually transmitted diseases (unsafe sex, using needles)? Yes No
4) Has your physical health kept you from participating in activities? Yes No

SUBSTANCE USE/ADDICTION PRESENT

1) Would you or someone you know say you are having a problem with alcohol? Yes No
2) Would you or someone you know say you are having problems with pills or illegal drugs? Yes No

SUBSTANCE USE/ADDICTION PAST

1. Would you or someone you know say you had problems with alcohol? Yes No Pills or illegal drugs? Yes No
2. Is there a family history of addiction? Yes No
3. If yes, please describe: _____

PERSONAL, FAMILY AND RELATIONSHIPS

1. Who lives with you? (parents, brothers, sisters, children, etc.) _____
2. Has there been any significant person or family member enter or leave your life in the last 90 days? Yes No
3. How are the relationships in your family? Good Fair Poor Close Stressful Distant Other
4. How are the relationships in your support system (friends, extended family, etc.)? Good Fair Poor Close Stressful Distant Other
5. Are there any problems in your family now? (circle all that apply) Conflict Abuse Stress Loss Other
6. Were there any problems with your family in the past? (circle all that apply) Conflict Abuse Stress Loss Other
7. Are there any problems in your support system now? (circle all that apply) Conflict Abuse Stress Loss Other
8. Were there any problems with your support system in the past? (circle all that apply) Conflict Abuse Stress Loss Other
9. What is your relationship/partnered status now? _____
10. Have you ever had problems with intimate/partnered relationships? Yes No
11. If yes, please circle why: Stress Conflict Loss Divorce/Separation Trust Issues Abuse Other _____
12. Do you have close friends? Yes No Do you have any problems with friendships? Yes No
13. What do you like to do for fun? _____

EDUCATION/ WORK

1. Please provide level of education: _____
2. What is your work history like? Good Average Below Average Poor
3. How long do you normally keep a job? _____
4. OTHER: Is there anything that you would like to share about you? Yes No (Use back of paper)

CLIENT TO KEEP

Therapist — Client Agreement
Sessions (Individual, Couples, or Family therapy)

Individual, Family, and Couple therapy sessions are 50 minutes long (unless otherwise discussed with therapist). In most cases, you will have a regular time and day weekly when you see your therapist. If no therapy session occurs for a month your case will be closed. We welcome and expect your active involvement in your therapy.

Fees

Payment is due at each session. If you wish to use our sliding fee scale, you must provide proof of income to your therapist at the time of the first session. If you choose, you may pay our full fee for service and not provide proof of income. You will sign a fee agreement for your set fee at the first session. All cash/self-pay clients will pay via check or cash no credit card accepted.

Cancellations

We hope you will attend all sessions and actively participate in therapy to resolve whatever has brought you to therapy. Please provide at least 24-hour notice if you must miss an appointment. Repeated cancellation, even with notice, may mean that your appointment time will not be held for you. If you miss two scheduled appointments in one month or three scheduled appointments in twelve weeks, your case will be closed and you will need to go through intake to re-enroll in services. You will be charged when you miss an appointment and do not provide 24-hour notice before the appointment time. You may leave voicemail for your therapist at any time by using the voice mail when you call Hope In Healing, Inc. 's main number. The voicemail system notes the date and time of your call. During your treatment if you do not attend a scheduled session and do not call to cancel the appointment, you will need to contact your therapist to schedule any future appointments, as your standing appointment will be removed from the therapist's calendar.

Staff and Client Treatment

You have the responsibility to treat Hope In Healing staff and clients with dignity and respect.
You are also expected to protect the confidentiality of the people served by Hope In Healing, Inc. Hope In Healing, Inc. reserves the right to not begin or to terminate a session with a client believed to be under the influence of drugs and or alcohol. You will be required to find a safe method of transportation to leave the premises if you arrive at Hope In Healing, Inc. under the influence of drugs and or alcohol.

Children at Sessions

Although Hope In Healing, Inc. wishes to be sensitive to family needs, we do not have the capacity to provide childcare. We do not allow children in counseling sessions unless they are the client of the session. Children may not be left unattended in the waiting area or vehicle.

Emergencies

Hope In Healing, Inc. does not provide 24 hour or emergency therapy services. Should you or someone close to you require such service, the following referrals are offered: 9-1-1 for emergency assistance Hotline to Help: 855-274-7471 Nearest hospital emergency room

Emergency Contact

Hope In Healing, Inc. requires that you give us contact information for a person we can contact in case of emergency. This contact will only be used if we believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

Emergency Contact Person: _____ **Relationship: _____**

Address: _____ Phone Number: _____

I AGREE FOR HOPE IN HEALING, INC. TO CONTACT THE ABOVE-NAMED PERSON UNDER THE ABOVE-NAMED CONDITIONS.

Hope In Healing, Inc. does not discriminate on the basis of sex, gender, sexual orientation, race ethnicity, color national origin, age, economic status, disability, marital status, HIV/AIDS status, religion, creed, Veterans status, or political beliefs. Your therapist is happy to inform you of the qualifications of the staff involved in providing your services. We hope that you will discuss any dissatisfaction with your therapist's services with the therapist.

All staff and contract therapists are committed to trying to resolve your concerns. Any staff member can tell you how to file a grievance and the contact information for the boards that license the Hope In Healing, Inc. therapists are posted in the therapist office. Expect that all communication and records related to your service will be treated as confidential and protected to the best of our legal ability. We expect that practicing therapist will maintain the confidentiality for the identity and disclosures of fellow group members. We also expect family members and significant others who attend therapy at Hope In Healing, Inc. will maintain the confidentiality of their fellow clients.

Please be aware however, that Hope In Healing, Inc. cannot guarantee that other clients will abide by this expectation. Hope In Healing, Inc. staff seek outside clinical supervision or consult with other professionals within the clinical counseling community in order to provide our clients with the best possible service.

Under certain circumstances, your therapist may be required to share confidential information under ethical and legal guidelines.

These limitations to confidentiality are:

1) When the client is believed to be an immediate danger to self or others
2) When therapist is told that abuse or neglect of a child or elderly or disabled person has occurred, even if that abuse occurred in the past. This means that sexual activity between a minor and an adult must be reported. Sexual activity between a child and an older child who is three years older that the younger child MUST be reported.
3) When a therapist is told about inappropriate behavior by a previous therapist, the therapist is obligated to report such abuse, however, the client's identity does not need to be disclosed if the client does not wish it.
4) When records are, court ordered by a judge o When you provide a written consent for release. You have a right to request to review your record and/or request an amendment or correction to your record. o You have the right to request a referral to another counseling resource.
5) You are becoming a client of Hope In Healing, Inc., rather than a client of a specific staff member. If the staff member providing your service leaves Hope In Healing, Inc., the therapist is obligated to facilitate appropriate transfer of your case to a therapist within the community. You may refuse any service or discontinue services at any time.

By signing below, you are indicating that you have read and understand this informed consent statement and that any questions you have had about this document or the therapy process have been addressed.

Signature: _____

Print: _____

Date: _____

Witness: _____

Release of Confidential Information Client initials: _____

READ FIRST: Before you decide whether or not to let Hope In Healing, Inc. share some of your confidential information with another agency or person, the therapist at Hope In Healing, Inc. will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Hope In Healing, Inc. to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Hope In Healing, Inc. has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Hope In Healing, Inc. to release some of my personal information to certain individuals or agencies.
I authorize Hope In Healing, Inc. to share the following specific information with:

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:

The information may be shared: In person Via: phone fax e-mail
☐ I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:	(List as specifically as possible, for example: name, dates of service, any documents).
Why I want my info shared: (purpose)	(List as specifically as possible, for example: to receive benefits).

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Hope In Healing, Inc.

I understand:

☐ That I do not have to sign a release form. I do not have to allow Hope In Healing, Inc. to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Hope In Healing, Inc. to release information about me in the future, I will need to sign another written, time-limited release.

☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Hope In Healing, Inc.

☐ That Hope In Healing, Inc. and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others. Expiration should meet the needs of the client, which is typically 30-60 days, but may be shorter or longer.

This release expires on (Date): _____/_____/_____
MM DD YYYY

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.
Signed: _____ Date: _____

Print: _____

Witness: _____ Relationship to client: _____

IF CLIENT CHOOSES TO EXTEND HIPPA RELEASE: (Please have client reaffirm extension)