Harpeth HILLS
COUNSELING CENTER

Intake Forms

Date _____

Demographic Information

Name _____ Date of Birth _____

Occupation _____ Employer _____

Education Level (highest completed) ∏ High School ∏ College (undergraduate)
∏ Graduate Level (Masters) ∏ Doctorate ∏ Other _____

Address _____

_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Fax _____

How may we contact you?

Phone contact: ∏ OK to leave message with detailed information?
∏ Home ∏ Cell ∏ Work

∏ Leave message with call back number only
∏ Home ∏ Cell ∏ Work

Written contact: ∏ Home address ∏ E-mail ∏ Fax

Referral Information

How did you hear about us?
- ∏ Referred by therapist _____
- ∏ Referred by a friend
- ∏ Referred by a minister/pastor _____
- ∏ Web Site
- ∏ Other _____

May we have your permission to thank the person who referred you to us? ∏ yes ∏ No

Emergency Contact Information

Name _____ Relationship _____

Phone #(s)_____

INTAKE ASSESSMENT

Presenting Problem

Reason(s) for considering therapy/counseling at this time? _____

_____

Areas of Concern or Stress

Personal or Relational Problems

- ∏ Grief/mourning following loss
- ∏ Depression
- ∏ Anger or difficulty controlling temper
- ∏ Loneliness
- ∏ Anxiety
- ∏ Guilt
- ∏ Physical problems
- ∏ Medical problems
- ∏ Financial difficulties
- ∏ Employment difficulties/stress
- ∏ Alcohol or drugs
- ∏ History of traumatic experiences
  - ∏ Sexual abuse ∏ Rape
  - ∏ Incest ∏ Assault
- ∏ Use of internet
- ∏ Pornography
- ∏ Arguing or handling conflict
- ∏ Poor Communication
- ∏ Infidelity
- ∏ Emotional abuse by partner
- ∏ Physical abuse by partner
- ∏ Lack of emotional support
- ∏ Problems with relatives
- ∏ Other concerns Please specify _____

_____

Life Adjustment Problems

- ∏ Divorce or Separation
- ∏ Newly married or remarried
- ∏ Stepfamily with children
- ∏ Moving to new location
- ∏ Parenting a newborn
- ∏ Being a single parent
- ∏ Addition of a parent to household
- ∏ Other adjustments Please specify:

_____

Family Problems

- ∏ Custody or visitation problems
- ∏ Disagreement about child rearing and/or discipline
- ∏ One or more family members not getting along
- ∏ Child(ren) having difficulty with divorce or new marriage
- ∏ Emotional abuse of child(ren)
- ∏ Physical abuse of child(ren)
- ∏ Sexual abuse of child(ren)
- ∏ Difficulty letting child(ren) grow up
- ∏ Major difficulties with child or teen

Please Answer the Following Questions Thoughtfully and Honestly:

Do you frequently daydream? _____ Have difficulty concentrating or maintaining focus? _____ Are you forgetful? _____ Procrastinate? _____ Frequently late? _____ Does anyone in your family complain? _____

How many hours do you work in a typical week? _____ Is this a good fit for your? _____ Does anyone in your family complain? _____

Do you have concerns or questions regarding your sexual activities or frequency? _____ Does your spouse express any concerns? _____

How frequently do you access the internet or play video games? _____ What type of sites do you visit? _____How much time are you on Facebook? _____
Does anyone in your family complain? _____

How frequently do you use tobacco products? _____ What type(s) of tobacco do you use? _____ What age did you begin? _____

Therapy/Counseling History

Have you ever been in therapy or counseling before? ☐ Yes ☐ No

When _____ Where _____

Reason _____

Describe the experience _____

Have you ever been hospitalized for any mental health reasons? ☐ Yes ☐ No

When _____ Where _____

Reason _____

Describe the experience _____

Are you currently in therapy or counseling with anyone? ☐ Yes ☐ No

Whom _____ Where _____

How long _____ Reason _____

Describe the experience _____

Dependency History

Have you ever felt like you needed to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

If yes to any of the above please describe _____

Have you ever been or are you now in treatment for alcohol/chemical dependency? ☐ Yes ☐ No

If yes, When _____ Where _____

Reason _____

Describe the experience _____

How frequently do you engage in high risk financial investments or gambling activities? _____

What are you doing? _____ How much money have you won/lost? _____

Does anyone in your family complain? _____

Relationship Information

Are you in a significant relationship at this time? ∏ Yes ∏ No

If yes, Name _____ Age _____ Date of Birth _____

∏ Dating ∏ Engaged ∏ Married ∏ Separated ∏ Divorced ∏ Living Together ∏ Other _____

How long have you been together? _____ If married, how long have you been married? _____

If separated, how long have you been separated?_____

How many times have *you* been married? ∏ 1 ∏ 2 ∏ 3 ∏ 4 or more

Age at first marriage _____ How long were you married? _____

How many times has *your partner* been married? ∏ 1 ∏ 2 ∏ 3 ◊ 4 or more

Age at first marriage _____ How long was he/she married? _____

Child(ren) Information

How many children do you have from current relationship? _____ Ages _____

How many children do you have from previous relationship(s)? _____ Ages _____

How many children does your partner have from previous relationship(s)? _____ Ages _____

How many children are currently living with you? _____ Ages _____

Do any of your children have problems or difficulties? ∏ Yes ∏ No

If yes, please explain: _____

_____

_____

Family of Origin

State/Country of birth _____ Where did you grow up? _____

Were you adopted? ∏ Yes ∏ No If yes, how old were you? _____

Did you live with both parents for most of the time from birth to high school? ∏ Yes ∏ No

Did your parents divorce? ∏ Yes ∏ No If yes, how old were you? _____

If you were not raised by both your natural or adopted parents, by whom were you raised?

∏ Single parent – mother ∏ Single parent – father ∏ Mom and step father
∏ Father and step mother ∏ Relative or guardian ∏ Other (specify)_____

How would you describe your parents' marriage?

∏ Very Happy ∏ Happy ∏ Neither happy nor unhappy ∏ Unhappy ∏ Very unhappy

Who do you know that has a marriage you would like to model your marriage after? _____
Why? _____

Biological Father

Name _____Occupation _____

Living? ∏ Yes ∏ No

If yes, give his current age _____ Health status _____
If no, give his age at time of death _____ Cause of death _____
How long ago did your father die? _____ How old were you? _____

Describe your relationship with your father _____

Does (or did) your father have any of the following (check all that apply)
∏ Alcohol/drug problem ∏ Depression ∏ Medical problems ∏ Mental Health concerns
∏ Compulsive behaviors such as gambling, sexual addiction, workaholism (specify) _____
_____

Biological Mother

Name _____Occupation _____

Living? ∏ Yes ∏ No

If yes, give her current age _____ Health status _____
If no, give her age at time of death _____ Cause of death _____
How long ago did your mother die? _____ How old were you? _____

Describe your relationship with your mother _____

Does (or did) your mother have any of the following (check all that apply)

∏ Alcohol/drug problem ∏ Depression ∏ Medical problems ∏ Mental Health concerns
∏ Compulsive behaviors such as gambling, sexual addiction, workaholism (specify) _____

_____

Religious History

Were you affiliated with any church/religion growing up? ∏ Yes ∏ No What church/religion? _____

Are you affiliated with any church/religion now? ∏ Yes ∏ No What church/religion? _____

Do you feel your present situation relates to your religious beliefs? ∏ Yes ∏ No Please explain _____

_____

Medical History

Physician Name _____ Phone Number _____
Address _____

_____

Date of Last Physical _____

Previous Health Problems (include surgeries) Date

_____ _____
_____ _____
_____ _____

Which of the following illnesses or complaints have you experienced recently?

____ Diabetes
____ Irregular menstrual cycle
____ Glaucoma
____ Seizures
____ Liver problems
____ Herpes
____ Back pain
____ Headaches/Migraines
____ Respiratory problems
____ Other _____
____ Head injury
____ High blood pressure
____ Sleep changes
____ Dizzy spells
____ Hepatitis
____ Kidney problems
____ Syphilis or other venereal disease(s)
____ Frequent constipation
____ Ulcer
____ Thyroid problem
____ Epilepsy
____ Appetite change
____ PMS
____ Asthma
____ Stroke
____ Heart Attack
____ Loss of consciousness

What prescription medications are you currently taking?

Medication Reason for taking it

1. _____
2. _____
3. _____

What over-the-counter medications do you take on a regular basis?

____ Diet pills/aides	____ Vitamins	____ Laxatives
____ Ibuprofen	____ Cough medicine	____ Stomach medicine
____ Sleeping pills	____ Sinus medicine	____ Aspirin

Females: Do you have *major* mood swings with your periods? ∏ Yes ∏ No
Do you have any of the following? ∏ Hot flashes ∏ Night sweats ∏ Painful intercourse
Are you on any hormone replacement therapy? ∏ Yes ∏ No
Have you discussed any difficulties with your doctor? ∏ Yes ∏ No

Males: Do you have sexual concerns/problems? ∏ Yes ∏ No
Have you discussed any difficulties with your doctor? ∏ Yes ∏ No

Is there other information your therapist needs to know? ∏ Yes ∏ No
Please explain_____
_____

_____ _____
Client Signature Date

_____ _____
Parent's Signature (if minor) Date

Harpeth Hills Counseling Center

Harpeth Hills Counseling Center is committed to providing quality, professional services that are guided by Christian values. It takes courage to schedule an appointment and share your personal difficulties with another person; and we commend you for taking this step. Most people pursue counseling because life has become complicated and confusing. Counseling is to help you better understand yourself, clarify your values and goals, and help you resolve the issues bringing you to counseling. It is also a cooperative effort between client and therapist and requires a commitment of time and energy.

Confidentiality – Privacy Practices

In accordance with HIPAA regulations, our clients' names and schedule of appointments are considered confidential information. This information will not be given to anyone regardless of the relationship, unless written permission for such an exchange is on file at the Harpeth Hills Counseling Center Disclosure of information is generally released only with your written permission. Exceptions to this rule include, but are not limited to: 1) if there is imminent danger to the client or another person, 2) if child or elder abuse or neglect is suspected, and 3) if the therapist is compelled by law to disclose client records or information. On occasion, with your verbal permission, your therapist will consult with other therapists in this office in order to more effectively help you. Your name will not be used in this group consultation.

Minors under the age of 16 years of age must have parental or legal guardian authorization for treatment. Parents and caregivers are asked to agree to limited access to information these minors share in session. If agreed, parents will be provided only general information about treatment or a summary of treatment. An exception to this is if the therapist feels there is a
high risk that a minor may seriously harm self or others. Minors who are 16 years of age or older must consent to services and written consent is not required from parents or legal guardians for their counseling services.

Couple therapy contains information about each person and both clients have a right to obtain such records that pertain to themselves. Both clients agree that treatment records will only be released by joint consent. Furthermore, there will be no secrets maintained by the therapist with one part of the couple about the other person in the couple relationship.

Fees

The fee for counseling services is $85.00 for a 50 minute session.

Upon your request, written information will be provided for you so you may file for reimbursement from your insurance company. Counseling is to be paid for on the day of the appointment and you will be charged $45 for appointments not canceled at least 24 hours prior to the appointment. If filing insurance, it is important to note that insurance companies will not pay for missed appointments and you will be responsible for the late cancellation or missed appointment.

I have read, understand and agree to the conditions described in this document.

Client Signature	Date
Client Signature / Spouse	Date
Parent or Guardian (if minor child)	Date

Harpeth Hills Counseling Center
and
HIPAA (Health Insurance Portability and Accountability Act)

HIPAA's privacy provisions are designed to protect patient private health information. These federal regulations apply to health care providers who file insurance for their clients electronically. Because the Harpeth Hills Counseling Center does not file insurance electronically, the Center is not required to adhere to the HIPAA regulations. However, the spirit of HIPAA is significant and therefore Harpeth Hills Counseling Center does voluntarily comply with all applicable components of the HIPAA regulations. For example, client files and therapist personal therapy notes for each client are kept in double locked files. Confidentiality is of utmost importance in the Counseling Center.

The Harpeth Hills Counseling Center takes very seriously the protection of our clients in every way and will continue to evaluate its practices and diligently guard the information with which it has been entrusted.

Please sign and date this document explaining Harpeth Hills Counseling Center's communication with you regarding the Federal HIPAA regulation and the Harpeth Hills Counseling Center.

_____ _____

Client Signature Date