ADULT INTAKE FORM

Name: _____ Date:

Date of Birth: _____ Social Security:

Home Address: _____ City, State, Zip:

Home Phone: _____ Work Phone:

Cell Phone: _____ Email Address:

May we call you and leave messages at home? ❑ Yes ❑ No

May we call you and leave messages at work? ❑ Yes ❑ No

May we send mail to you at this address? ❑ Yes ❑ No

Marital Status: ❑ S ❑ M ❑ D ❑ W Date of Current Marriage/Separation: _____

Number of Marriages:

Spouse's Name: _____ Date of Birth:

Child(ren)'s Name(s): _____

Date of Birth: _____ ❑ M ❑ F

Date of Birth: _____ ❑ M ❑ F

Date of Birth: _____ ❑ M ❑ F

Previously Married? ❑ Yes ❑ No If yes, when? _____ How long?

Occupation: _____ Highest Level of Education:

MEDICAL HISTORY

How would you rate your current physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? ❑ Yes ❑ No

If yes, please explain:

Previous hospitalizations for medical reasons Date: _____ Reason:

Date: _____ Reason:

Please list any medical conditions or disabilities:

Please list any learning disabilities:

MEDICATION(S) **Over-the-counter or prescription**	**DOSAGE**

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? ❑ Yes ❑ No If yes, when? _____ Name and location of counselor:

If yes, for what reason? _____ For how long?

Have you ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type?

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type?

PSYCHIATRIC MEDICATION(S)	**DOSAGE**

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today?

Where are your concerns causing the most problems for you? Please check all that apply:

❑ Home ❑ Work ❑ Marriage ❑ Other Relationships ❑ God

When did your present concerns begin to be a problem for you?

What concerns about you have been identified by others?

Have you ever attempted suicide? ____No ____Yes. If yes, please describe the nature of the event(s) and the date of the occurrence(s).

_____

Please rate the severity of your present concerns on the following scale. Check one:

❑ Mild ❑ Moderate ❑ Severe ❑ Totally Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply:

- ❑ Feeling inferior to others
- ❑ Under too much pressure and feeling stressed
- ❑ Feeling down or unhappy/depressed mood
- ❑ Excessive anxiety or worry
- ❑ Feeling lonely
- ❑ Suspicious feelings toward other people
- ❑ Afraid of being on your own
- ❑ Angry feelings
- ❑ Concerns about finances
- ❑ Feeling "numb" or cut off from emotions
- ❑ Concerns about physical health
- ❑ Concerns about emotional stability
- ❑ Tremors
- ❑ Blackouts or temporary loss of memory
- ❑ Insomnia (not being able to sleep)
- ❑ Loss of appetite/increased appetite
- ❑ Uncontrollable anxiety or worry
- ❑ Lacking self-confidence
- ❑ Feeling fat
- ❑ Eating and then vomiting to control weight
- ❑ Excessive use of alcohol
- ❑ Abuse of non-prescription drugs
- ❑ Getting into trouble at school/work
- ❑ Other: _____
- ❑ Not being able to say what you really think or feel
- ❑ Angry outbursts
- ❑ Excessive fear of specific places or objects
- ❑ Difficulty making friends
- ❑ Difficulty keeping friends
- ❑ Feeling as if you'd be better off dead
- ❑ Feeling manipulated or controlled by others
- ❑ Difficulty making decisions
- ❑ Loss of interest in sexual relationships
- ❑ Feeling sexually attracted to members of your own sex
- ❑ Feeling distant from God
- ❑ Hallucinations
- ❑ Hypersomnia (sleeping all the time)
- ❑ Inability to concentrate while at school/work
- ❑ Crying spells
- ❑ Feeling "on top of the world"
- ❑ Nightmares
- ❑ Loss of interest in usual activities/lack of motivation
- ❑ Obsessions or compulsions with specific activities
- ❑ Inability to control thoughts
- ❑ Feeling trapped in rooms/buildings
- ❑ Hearing voices
- ❑ Feeling that people are "out to get you" or that you are being watched
- ❑ Delusions

What do you hope to gain from counseling?

How did you hear about us? ❑ Friend ❑ Church ❑ Pastor ❑ Other:

SPIRITUALITY

Do you believe in God? ❑ Yes ❑ No What is your religious preference?

Are you a member of a church? ❑ Yes ❑ No If yes, what church?

How much influence does your religion have on your day-to-day activity? ❑ A lot ❑ A moderate amount ❑ A little ❑ None

EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

_____

Client Signature_____ Date _____

Therapist Signature _____ Date_____

MICHAEL DEVINE COUNSELING

CLIENT RIGHTS & RESPONSIBILITIES

METHOD OF TREATMENT
Counseling methods combine brief, solution-focused therapy and an emphasis on relational dynamics. A positive approach to problems is taken, believing that people are resilient and have tremendous resources to address life situations. It is the role of the counselor to help the client understand the dynamics of his/her situation and to assist him/her in using his particular strengths to address these issues.

GOALS, RISKS & BENEFITS
There is always a risk of emotional side effects from counseling. *Sometimes symptoms worsen before they get better*. Often counseling brings up painful emotions. Our goal is to confront issues and emotions together and to work through them over time. Other types of counseling such as support groups or therapy groups may also be appropriate in a particular situation. Together, the client and counselor will determine if one or more types of counseling are appropriate.

LENGTH OF TREATMENT
Length of treatment will vary and will be determined together by the client and counselor. Each individual and relationship has unique strengths and weaknesses, and each problem is different from the next. The goal is that each client will finish counseling in a timely manner, without unnecessary use of time or money. Groups will have a pre-determined number of sessions, typically six to ten.

FEES
Together, the client and counselor will make decisions concerning how often and for how long they should meet. Counseling sessions will be 45-50 minutes long at a cost of $115 for initial session/intake $115 for individual therapy/coaching sessions. Marriage, and pre-marital sessions are $115 per session and $115 for family sessions. Personal checks, credit cards, and cash are accepted for payment. Payment is due in full at each session,

INSURANCE MAY REIMBURSE ALL OR PART OF COUNSELING FEES. Michael DeVine, M.S. LPC Counseling Services DOES NOT FILE INSURANCE; HOWEVER, DOCUMENTATION IS PROVIDED SHOULD THE CLIENT CHOOSE TO FILE WITH HIS INSURANCE PROVIDER.

All fees incurred for lost time/wages because of court hearings, subpoenas served, or other legal matters regarding client(s) business will be paid in a timely manner by the client(s) signing below. Wages to be paid will consist of $220/hr minimum.

Keep your receipts in a safe place for insurance/tax purposes. Clients sometimes ask for additional copies of receipts. While we are happy to be of service to you, this is a time consuming process for our administrative staff. Therefore, like other organizations, we charge a **$25** fee for this service, to cover the cost of labor, copying, and postage or fax.

CANCELLATIONS
In the event the client is unable to keep an appointment, notification is required at least 24 hours in advance. The client is required to pay for any missed sessions unless he calls 24 hours in advance to cancel the appointment. An exception may be made if your therapist deems the situation an emergency. Session Cancelation Fee: $100

RIGHT TO PRIVACY/CONFIDENTIALITY
All communication between the client and counselor becomes part of the clinical record. Records are the property of Michael DeVine Counseling in accordance with legal requirements, adult client records are disposed of seven years after the file is closed; minor client records are disposed of seven years after the client's 18th birthday.

<u>While most communication between a client and counselor is confidential, the following limitations and exceptions do exist:</u>

- The counselor determines the client is a danger to himself or someone else.
- The client discloses abuse, neglect or exploitation of a child, elderly or disabled person.
- The client authorizes the counselor to release records.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information. *In marriage or family counseling, the meaning the confidentiality belongs to the relationship and not the individual.*

EMERGENCIES

During office hours, the client can contact the counselor at **972-473-0500 Ext 132**. If the client is unable to reach his counselor in a timely manner, client should contact his physician, a local emergency room or the local police department when necessary and appropriate. It is the client's responsibility to seek the appropriate resources in emergency situations.

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. By your counselor's signature, Michael DeVine Counseling verifies the accuracy of this statement and acknowledges our commitment to conform to its specifications.

Client or Guardian Signature: _____ Printed Name: _____ Date: _____

Counselor Signature: _____ Printed NameDate: _____ Date: _____