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

Consent to Contact Agreement

Harpeth Hills Counseling Center may occasionally need to contact you. You have the right to opt-in or opt-out of these communications. We will never communicate any Protected Health Information (PHI) in any of these instances. These communications will be used only to inform you about appointments or about workshops for which you have requested information.

Cancellation Policy

____ **(*initial*) It is always the client's responsibility to communicate appointment cancellations by phone 615-690-4661 at least 24-hours in advance of appointment time. If no one is available to take your call, voicemails left 24-hours in advance will be honored. Failure to give a 24-hour notice will result in a $45 Late Cancellation fee.**

Risks of Electronic Communications

a) Email and text messages are not completely confidential.
b) Emails are retained in the logs of Internet service providers. While it is unlikely that someone will review these logs, they are, in theory, available to be read by the system administrator of Internet service providers. Likewise, if you choose to have reminders sent to your work or other non-personal email, they are available to be read by the system administrator.
c) Wireless providers may retain archives of text messages even after they have been deleted.
d) There is a possibility that email and text messages may be seen or intercepted by someone other than the intended recipient.
e) There is the possibility that email and text messages may be sent to an incorrect email address or phone number.
f) Please also be aware that any email or text communication between you and your therapist or the Counseling Center becomes part of your record.

Types of Contact Consent (Please choose and complete the one that applies to you.)

I. Contact Consent for Individuals
II. Contact Consent for Couples
III. Contact Consent for Minors

Contact Consent for Individuals

If you would like to receive appointment reminders 24-hours in advance of your appointment, please select how we may contact you. You may choose more than one.

I acknowledge that text and email reminders may not take place. I understand that the responsibility to attend, reschedule or cancel an appointment rests with me.

I acknowledge that it is my responsibility to inform the Counseling Center of any email address or phone number changes.

___ You may **TEXT** me at the following phone number _____

___ You may email me at the following email address _____

Email Appointment Reminders will be in the following format and may go to your spam folder until you have added the email address to your address book.
Appointment Reminder <yourprovider@simplepractice.com>

___ You **do not** have permission to contact me for the purpose of Appointment Reminders.

Contact Consent for Couples

If you see a therapist as a couple, and you choose to receive appointment reminders, you must designate who receives appointment reminders. One person may be designated to receive reminders or both parties may be designated to receive reminders. What does this mean? Whether you and your spouse/significant other/partner have individual appointments with the same therapist or separate appointments with the same therapist, only one reminder will be sent; it will either go to the designated member or to both. The reminder will not identify who has the appointment; so, the responsibility shall rest with the couple to attend the appointment individually or together.

Appointment Reminders for Couples

If you would like to receive appointment reminders 24-hours in advance of your appointment, please select how we may contact you. You may choose more than one.

I acknowledge that text and email reminders may not take place. I understand that the responsibility to attend, reschedule or cancel an appointment rests with me.

I acknowledge that it is my responsibility to inform the Counseling Center of any email address or phone number changes.

I designate the following person/persons to receive appointment reminders for both couple and individual appointments.

Name: _____

___ You may **TEXT** me at the following phone number _____

___ You may email me at the following email address _____

Name: _____

___ You may **TEXT** me at the following phone number _____

___ You may email me at the following email address _____

Email Appointment Reminders will be in the following format and may go to your spam folder until you have added the email address to your address book.

Appointment Reminder <yourprovider@simplepractice.com>

Name: _____

___ You **do not** have permission to contact me for the purpose of Appointment Reminders.

Name: _____

___ You **do not** have permission to contact me for the purpose of Appointment Reminders.

Contact Consent for Minors

Appointment reminders for all minors under the age of 16 will be sent to the guardian. Appointment reminders for minors 16 years or older will be sent to the minor ONLY unless the minor gives written consent for reminders to be sent to the guardian. Such written consent should be discussed and given to your therapist.

Appointment Reminders for Minors

If you would like to receive appointment reminders 24-hours in advance of your appointment, please select how we may contact you. You may choose more than one.

I acknowledge that text and email reminders may not take place. I understand that the responsibility to attend, reschedule or cancel an appointment rests with me.

I acknowledge that it is my responsibility to inform the Counseling Center of any email address or phone number changes.

Please choose and complete the appropriate option.

___I am the guardian for a minor under the age of 16.

Name: _____

___I am the client and 16+.

Name: _____

___I am the client and 16+. I give permission for me and my guardian to receive appointment reminders. This option must be discussed with the assigned therapist.

Name: _____

___ You may **TEXT** me at the following phone number _____

___ You may email me at the following email address _____

___ You **do not** have permission to contact me for the purpose of Appointment Reminders.

Email Appointment Reminders will be in the following format and may go to your spam folder until you have added the email address to your address book.

Appointment Reminder <yourprovider@simplepractice.com>

Appointment Notifications

There will be times when your therapist or the Counseling Center needs to cancel or change your appointment time or date.

In the event your therapist or the Counseling Center needs to cancel your appointment or change your appointment time or date, please indicate all means by which we have permission to contact you. In each instance, please list the phone number and\or email that you give consent to contact. (**Please note in rare instances you may not receive the notification until after your original appointment time.)**

___ You may call me at the following phone number _____

___ If I am unavailable to take your call, you may leave a message on the number above.

___ You may email me at the following email address _____

___ You **do not** have permission to contact me for the purpose of Appointment Notifications.

Other Notifications

Periodically, the Counseling Center facilitates workshops and other events that address specific topics.

If your therapist feels one of these workshops or events would be beneficial for you, we'd like your permission to inform you of upcoming dates and times.

If you would like to receive these notifications, please select how we may contact you. You may choose more than one.

___ You may call me at the following phone number _____

___ If I am unavailable to take your call, you may leave a message on the number above.

___ You may email me at the following email address _____

___ You **do not** have permission to contact me for the purpose of workshops or other events.

Change in Contact Information or Consent to Contact Permission

If your phone number or email address changes, it is your responsibility to inform Harpeth Hills Counseling Center. If your desired consent for contact changes, it is your responsibility to inform the Counseling Center.

Acknowledgements

I acknowledge that I have read the Consent to Contact Agreement in its entirety. I acknowledge that I have been offered the opportunity to receive a written copy of this Agreement.

I acknowledge that I have been given the opportunity to review and ask for clarification of the Consent to Contact procedures. I also acknowledge that I have been given the option to opt-out of contact from the Counseling Center for the purpose of Appointment Reminders, Appointment Notifications and Other Notifications.

Signature(s)

For couples counseling, both parties must sign and date. For minors giving consent for guardian contact, both parties must sign and date.

_____ _____

Printed Name Date

_____ _____

Signature Date

_____ _____

Printed Name Date

_____ _____

Signature Date