Client Intake Form

Philip Zimmerman
MaMFT – Spirituality and Counseling

Demographics

Name:_____ Date: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Church attended (if applicable)_____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (years married ____) **Divorced** **Widowed**

Spouse's name (if married):_____

Children:	Name	Age

Gross Annual Income (before taxes) $_____

Do you receive food stamps, alimony or child support? _____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

Physician _____ Current Medications _____

Are you on disability? . Please describe _____

Are you currently taking medication for a mental or emotional condition? _____

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

_____

Do you currently use any alcohol or drugs? _____ If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? _____

If yes, please describe: _____

Reasons for seeking counseling:

_____

_____

_____

_____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Current Experience Checklist

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Please Mark Those That Apply to the Client

- ❑ 1. Depressed Mood
- ❑ 2. Lost interest in most activities
- ❑ 3. Increased appetite
- ❑ 4. Decreased appetite
- ❑ 5. Weight Gain
- ❑ 6. Weight Loss
- ❑ 7. Difficulty going to sleep
- ❑ 8. Difficulty staying asleep
- ❑ 9. Fatigue, loss of energy
- ❑ 10. Feelings of worthlessness
- ❑ 11. Inappropriate guilt
- ❑ 12. Difficulty concentrating
- ❑ 13. Preoccupation with death
- ❑ 14. Suicidal thoughts
- ❑ 15. Excessive or uncontrollable worry
- ❑ 16. Restlessness
- ❑ 17. Irritable
- ❑ 18. Decreased need for sleep
- ❑ 19. Increased talking
- ❑ 20. Racing thoughts
- ❑ 21. Distractible
- ❑ 22. Elevated mood
- ❑ 23. Engaging in risky, pleasurable activities
- ❑ 24. Mood swings
- ❑ 25. Feelings of panic
- ❑ 26. Pounding heart, chest pains, shaking
- ❑ 27. Shortness of breath, dizziness, sweating
- ❑ 28. Recurrent undesirable thoughts
- ❑ 29. Repetitive behaviors (hand washing, checking) or mental acts (counting etc)
- ❑ 30. Nausea or abdominal stress
- ❑ 31. Fear of losing control
- ❑ 32. Fear of dying
- ❑ 33. Recurrent intrusive memories
- ❑ 34. Flashbacks
- ❑ 35. Efforts to avoid memories
- ❑ 36. Fear of social situations
- ❑ 37. Alcohol problems
- ❑ 38. Drug use problems
- ❑ 39. Compulsive dieting
- ❑ 40. Vomiting, use of laxatives
- ❑ 41. Marital problems
- ❑ 42. Sexual problems
- ❑ 43. Impulsive
- ❑ 44. Overwhelmed
- ❑ 45. Angry
- ❑ 46. Easily upset, on edge
- ❑ 47. Careless, forgetful, easily, distracted, difficulty organizing, loses thing

Practice Policies

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In order to answer questions that are frequently asked by clients regarding fees, confidentiality, services, etc., I have developed these policy statements for your information. I value you as a client and want you to be informed.

Fee Policy

I am committed to offering the highest quality, professional counseling, coaching and spiritual direction services. My current regular fees are as follows. You will be given advance notice if my fees should change.

My fee for all types of services is $90 per session (clinical hour). A session is typically based on a 50-minute hour. I request that cancellations be made 24 hours in advance; otherwise, you will be billed for the full session fee. I take payment and schedule for the next week at the beginning of each appointment. If you do not have your payment at the beginning of session we will have to reschedule to another time when you can make the payment. You will owe for that session as well as the rescheduled one. I currently do not accept insurance or credit cards. However, I do allow my clients to post-date their checks for up to one week (seven days) after the date of their visit if necessary. Inpatient visits or significant telephone counseling, etc. are based on the same fee you would pay for an in-office visit in addition to transportation expenses. I do not testify unless required by a court order. Court appearances or related calls and documentation are $180 per hour.

Confidentiality

Professional ethics and Tennessee State law indicate that confidential information is controlled by the client. This means that, as a general rule, information shared in sessions with a counselor will be held in confidence. There are two exceptions to this general rule, however. In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality. Secondly, Tennessee law requires that child abuse in any form be reported to the Department of Human Services or other authority such as a Juvenile Judge. If you are referred by a physician or other health care professional, it a professional courtesy to maintain contact, as necessary, with that referral source. That may be done unless you request otherwise.

Professional Services

I am available for counseling, coaching and spiritual direction appointments on Thursdays with additional appointments as needed. The phone number listed on my business card is the number you can reach me at in case of an emergency or to schedule or cancel a session. If for some reason you should be unable to contact me during an emergency, you may obtain assistance by calling the Crisis Help Line at 244-7444, the YW Domestic Violence Center at 242-1199, or by going to your local hospital emergency room.

Benefits and Risks of Counseling

Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. They may change employment and begin to feel differently about themselves, and may change other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Credentials

I have earned my Master's degree in Marriage and Family Therapy from Richmont Graduate University with a specialization in Counseling and Spirituality. I am in a post-graduate licensure process under the supervision of Dr. Susan Lahey (Licensed Marriage and Family Therapist #634). I work with individuals, couples and families on a variety of counseling needs. I have completed Level 1 of EMDR training and am also trained in professional coaching.

- Do you have any questions about fees, confidentiality, or other matters? Yes____ No____
- Do you agree with the conditions and provisions of these Practice Policies? Yes____ No____

Signature of Responsible Party(ies):

_____ Date:_____ _____ Date:_____

HIPAA Privacy Practices

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I am required by law to follow the practices described in this notice. This letter is a summary of our Privacy Practices, but does not replace the full version which has been made available to you. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this facility. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Office for this facility.

Who Has Access To Your Personal Information?

Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social
- Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
    1. We did not create the entry
    2. The information is not part of the file we keep; or
    3. The information is not part of the file that we would let you see; or
    4. We believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years.
- The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example-not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other released of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

Signature of Responsible Party(ies):

_____