Initial Therapy Intake Form

Thank you for taking the time to answer this questionnaire! This will help to better understand your clinical issues and design a treatment plan to address your unique situation.

Today's Date: _____

Name_____ Age_____ Date of Birth_____

If client is a minor, name of responsible adult (guardian) _____

Address_____ City _____State _____ Zip _____

Preferred Phone Number_____ May we leave a message? □ Yes □ No

Preferred email _____

Are there any concerns receiving correspondence from this office to the contact info you provided? ___Yes ____No

EMAIL CORRESPONDENCE: If you wish to communicate via electronic mail (email and text messages) please initial below. Be aware that I do not have encrypted email software and cannot guarantee that information transmitted by email ot text will not be intercepted or read by other parties. By initialing below you agree not to hold Barbara Schmitt, LPC-MHSP/Tranquility Counseling LLC responsible for any breach of confidentiality that may occur by information contained in emails. **INITIAL :** _____ Would you like reminders of upcoming appointments? ___Yes ____No

Would you like access to our Client Portal? ___Yes ____No

Emergency Contact person: _____ Relationship _____ Phone: _____

Address _____

In an emergency, do I have permission to contact this person, identifying myself as your counselor? ___Yes ____No

If no please indicate your concerns: _____

INSURANCE INFO (please provide insurance card and photo ID to provider)

Insurance Company _____ Phone Number: _____

Insurance ID #: _____ Group Number: _____

Employer: _____

If not policy holder, then state name, address, DOB, & phone number of holder:

Name_____ DOB _____ Relationship _____ Phone Number _____

Address_____ City _____ State _____ Zip _____

Co-pay amount $ _____

MEDICAL / HEALTH STATUS: Please describe any major medical problems or health issues?

_____

History of any hospitalizations (medical and/or psychiatric): _____

_____

Please list any developmental delays or learning disabilities _____

Please list current medications: _____

Name of Primary Care Physician: _____ Phone: _____

Address_____ City _____ State _____ Zip _____

Do you consent for release of information between Barbara Schmitt, LPC-MHSP & PCP? ___Yes ____No

MENTAL HEALTH STATUS: Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ___Yes ____No.

Previous diagnoses? □ Anxiety □ Depression □ Bipolar □ ADD/ADHD □ Other _____

If yes, what type of therapy and how long did you attend? _____

_____

Was therapy beneficial to you? Why did you feel it helped/didn't help? _____

_____

_____

Are you currently in treatment with any other counselor or psychiatric provider? ___Yes ____No

Name of Psychiatrist (if applicable): _____Phone: _____

Current psychiatric medications not listed above: _____

SUICIDAL THOUGHTS:

____I am experiencing these thoughts now

□ Mild: some thoughts, no plan

□ Moderate: some thoughts, vague plan, low levels of lethality

□ Severe: significant thoughts, plan is specific and lethal

____ No current suicidal thoughts

□ I have never had thoughts of suicide

□ I have experienced thoughts in the past.

□ I last experienced this on date:_____

Have you ever attempted suicide at any time in your life? ___Yes ____No

If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:

_____

_____

Please ✓ any of the following symptoms that you have experienced related to your mental health:

□ insomnia	□ feeling anxious	□ excessive worry	□ fear of worst happening
□ fear of dying	□ unable to relax	□ panic attacks	□ social anxiety
□ depressed mood	□ decreased energy	□ feelings of guilt	□ feelings of worthlessness
□ loss of motivation	□ loss of interest in usual activities		□ isolation
□ self harm	□ easily annoyed or irritable		□ chronic feelings of anger

How long have you experienced these symptoms? _____

THERAPY GOALS AND CLIENT STRESSORS

What do you wish to achieve through therapy at this time?_____

_____

_____

Presently, and during the last two years, what are/have been some of the stressful events in your life (death of a loved one, loss of a relationship, job loss, family difficulties, disappointments, etc)?

_____

_____

_____

_____

RELATIONSHIP STATUS

___Single ___Married ___Divorced ___Remarried ___Separated___Widowed ___Engaged ___Living Together

Spouse's/Significant Other's name (if this applies): _____
Length of time together:_____
Your children's names and ages (if applicable): _____
Who currently lives in your home: _____
_____
Please identify any areas of need or struggle in your present relationships: _____
_____
_____

Please identify any areas of significant conflict or trauma that you have experienced in your past or present relationships (ie: emotional abuse, verbal abuse, physical abuse, adultery/affairs, financial problems, sexual addiction, alcohol and/or drug addictions, domestic violence, etc): _____
_____
_____

Are any sexual issues causing problems in your life at this time? (pornography addiction, prostitution, infidelity, sexually transmitted diseases, lack of desire, ED, etc.)? If so, please explain: _____
_____

FAMILY/RELATIONSHIP HISTORY: Please describe your relationship with your parents. Are both parents living? Are they your biological parents? Are they still married or are they divorced? Is this their first marriage? How do you get along with them? _____
_____

Family Psychiatric History: _____

Do you have a trauma or abuse history (victim of or witness to physical or sexual abuse, domestic violence, surviving a rape, a severe auto accident in which someone was killed, seeing someone shot/killed, surviving a tornado, traumatic losses, difficult upbringing, etc). If yes, please describe:
_____
_____
_____

Please ✓ any of the following symptoms that you have experienced related to your trauma:

□ obsessive thoughts	□ emotional numbness	□ chronic hopelessness	□ flashbacks
□ insomnia	□ nightmares	□ lethargy/ no energy	□ despair
□ chronic feelings of anger		□ intrusive images	□ isolation
□ impaired family and social relationships		□ history of substance abuse to self-medicate feelings	
□ intense fear of abandonment or intimacy		□ hyper-startle (intense responses to specific triggers)	

EDUCATION/OCCUPATION:

Educational background: □ GED □ High School Diploma □ Some College □ College Degree □ Military

Occupation_____ Employer_____ Length of employment _____

Please describe any occupational stressors: _____

Substance Use/Addiction History

ALCOHOL USE/ABUSE/DEPENDENCY: Do you drink alcohol more than once a week? **Yes / No**

Age of first use: _____ Age of regular use _____ Age of last use: ____ Frequency/Amts: _____

Have you ever felt you needed to cut down on your drinking? (circle) **Yes / No**
Have people annoyed you by criticizing your drinking? (circle) **Yes / No**
Have you ever felt guilty about drinking? (circle) **Yes / No**
Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover? (circle) **Yes / No**

SUBSTANCE USE/ABUSE/DEPENDENCY:
How often do you engage in recreational drug use? □ Daily □ Weekly □ Infrequently □ Never

Age of first use: _____ Age of regular use _____ Age of last use: ____ Frequency/Amts: _____

Which of the following have you experienced related to your alcohol or substance use (circle):

Blackouts Memory Loss Increased Tolerance Decreased Tolerance Withdrawals Increased Isolation
Withdrawal from social activities Occupational problems Financial problems Legal charges/issues

Please ✓ any of the following symptoms that you have experienced related to your addiction:

□ Driving under the influence □ Serious motor vehicle accidents □ Working under the influence □ IV drug use

□ Falls with injuries □ Legal problems ___ arrests ___ convictions ___ jail time ____ DUI (s)

Please list your longest length (s) of sobriety _____ When? _____
Please list previous Drug & Alcohol Treatment episodes:

Date_____ Location _____ Length of treatment _____

Date_____ Location _____ Length of treatment _____

Do you have knowledge/experience in 12-Step programs (AA, NA, OA, CODA, SLAA, AlAnon, etc)? ___Yes ____No

Was a 12-Step program beneficial to you? ___Yes ____No Why did you feel it helped/didn't help? _____
_____

Do you have a 12-Step sponsor? ___Yes ____No Have you worked the Steps? ___Yes ____No

Is there a history of substance abuse in your family? If so, describe who, what substance, etc.:_____
_____

Do you struggle with compulsive or addictive behaviors/"process addictions" such as:
□ Overeating □ Constantly working □ Extreme shopping binges □ Gambling □ Sexual acting out □ Other
Please describe_____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

_____ _____

Client Signature (if completed by client) **Date**
Signature of Legal Guardian of Client under the age of 16

Barbara Schmitt, LPC-MHSP
Tranquility Counseling LLC, 2685 N. Mt. Juliet Rd., Mt. Juliet, TN 37122
Phone *615-553-2354 Cell 615-202-0608*

ACKNOWLEDGEMENT OF HIPAA NOTICE OF THERAPISTS' PRIVACY PRACTICES, POLICIES, AND PROCEDURES

Please read and initial next to each item and sign the form below.

_____ I acknowledge that I have received a copy of the **HIPPA Notice of Therapists' Policies and Procedures**. By signing below, I acknowledge having read, understood, and agreed to these policies and processes; including the financial agreement and issues of confidentiality.

_____ I give consent to contact my identified emergency contact in the event of a psychiatric emergency.

_____ I give consent to be contacted by my therapist by phone, email and that it is acceptable to leave a voice message for me on the number provided.

_____ I give consent to my therapist, Barbara Schmitt, LPC-MHSP, to provide clinical treatment in the context of the counseling relationship.

CLIENT RESPONSIBILITY FOR PAYMENT POLICY

Payment for sessions should take place at the beginning of the counseling session. A receipt will be provided in the event you would like to submit your bill to your insurance company for possible coverage of these services. *It is the responsibility of the client to pay for any sessions that are cancelled or missed without 24-hours notice prior to that missed appointment.* Clients assume responsibility for a $50 missed session fee for missed appointments. This policy allows Barbara Schmitt, LPC-MHSP to maintain consistent billing practices with all clients and requires a commitment by the client to have a financial responsibility tied to the counseling relationship. If you have any questions about this policy, please discuss them during your opening session.

_____ _____
Client Signature **Date**

_____ _____
Signature of Legal Guardian of Client under the age of 16 Date

_____ _____
Therapist Date