# **CONFIDENTIAL CLIENT INTAKE FORM**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: □Male □Female Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly attend a church, synagogue, or other religious institution? □Yes□No

If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## RELATIONAL INFORMATION

Current marital status: □Single □Engaged □Married □Separated □Divorced □Widowed

If engaged, married, separated, divorced, or widowed, for how long? \_\_\_\_\_\_\_

Number of previous marriages for you. \_\_\_\_\_\_\_\_\_ For your spouse. \_\_\_\_\_\_\_

If married, spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

Is your spouse supportive of you seeking counseling? □Yes □No □Unsure □Spouse doesn’t know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your level of satisfaction with your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please list your children (including step, adopted, foster) below: |
| Name | Sex | Age or yr. of death | Relationship to you | Living with whom? |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
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Who else lives with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Sex | Age or yr. Of | Relationship to | Describe him/her (e.g. angry,  |
|  |  | death | you | outgoing, supportive, controlling) |
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**COUNSELING HISTORY**

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

|  |  |  |
| --- | --- | --- |
| Therapist's Name or Program | Major Issue | Dates |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?

□Yes □No

 If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of your family members or friends ever attempted or committed suicide?

□Yes □No

 If yes, who and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving any medical treatment? □Yes □No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.) |
| Name of medications | Dose | Reason for taking |
|  |  |  |
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Are you taking these medications according to the doctor’s recommendations?

□Yes □No

 If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the following symptoms or problems that you currently are or recently have experienced:

|  |  |  |
| --- | --- | --- |
| List 1 | List 2 | List 3 |
| □ Stress | □ Marital Problems | □ Compulsive Behaviors |
| □ Anxiety | □ Other Relational Problems | □ Seeing Things Others Don’t |
| □ Panic | □ Physical Abuse | □ Hearing Voices |
| □ Depression | □ Emotional Abuse | □ Racing Thoughts |
| □ Apathy | □ Verbal Abuse | □ Eating Problems |
| □ Fatigue/Lack of Energy | □ Sexual Abuse | □ Drug Use |
| □ Loss of Appetite/Overeating | □ Sexual Problems | □ Alcohol Use |
| □ Trouble Sleeping | □ Gender Identity Issues | □ Pregnancy |
| □ Poor Concentration | □ Anger | □ Abortion |
| □ Feeling Worthless | □ Aggressive Behavior | □ Legal Matters |
| □ Recent Death | □ Bad Dreams | □ Work Stress |
| □ Grief | □ Unwanted Memories | □ Career Choices |
| □ Chronic Pain | □ Loss of Control | □ Indecisiveness |
| □ Loneliness | □ Impulsive Behavior | □ Parenting Problems |
| □ Fears | □ Controlling | □ Financial Problems |
| □ Shyness | □ Controlled by Others | □ Spiritual Problems |
| □ Low Self-Esteem | □ Obsessive Thoughts | □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please use an “X” on the scale below to indicate how distressing your problem(s) are to you.

[----------------------------------------------------------------------------------------------------------]

Very Moderately Very

 Minimally Distresed Extremely

 Distressed Distressed

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have you attempted suicide in the past?

□ Yes □ No

Are you currently experiencing any violent or homicidal thoughts? □ Yes □ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature Date

POLICIES AND PROCEDURES

 Please read all documents thoroughly and complete them where necessary, so that you are prepared to discuss any questions with me during your first session.

1. RELEASE OF INFORMATION FORM

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with me are confidential unless you have SIGNED a consent form to release part or all of the information.

Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1) the client is a clear danger to (a) themselves or (b) others and, 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical or sexual abuse, and 3) there is any suspected abuse to a child or adult. Please sign and date all Release of Information documents.

In addition, cases may be anonymously discussed with other licensed professionals in order to obtain feedback and provide alternative treatment plans and continuity of care. Your signature on this form will allow this process to proceed smoothly.

2. TELEPHONE CALLS

Occasionally the need to talk may arise between normally scheduled sessions. It is difficult to conduct psychotherapy over the phone but I will respond to your call during my normal business hours. A charge will be incurred by the client for any telephone consultation time between scheduled sessions. If there is an emergency and I am unable to be reached, call 911 or go immediately to your local Emergency room.

3. LENGTH OF SESSION

The psychotherapy session is about 45-50 minutes in length. It is to your benefit to arrive a few minutes in advance of the appointment time. Since I have sessions scheduled after yours, the sessions must end 45-50 minutes after the appointment time regardless of your arrival time (full fee for the session will be charged).

4. FEES AND PAYMENT

All payments are due at the time of service. I accept cash or check made payable to Mike Sorenson, LPC. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. My current fee per session is $75. If any or all outstanding balances are not paid, I reserve the right to release a client’s name and address to a collection agency.

5. INSURANCE

I do not currently accept health insurance payments. All payments are paid by the client at the time of service. In some cases, an individual’s health insurance plan will reimburse for fees paid. I am able to provide receipts for fees paid, but the responsibility for coordinating the reimbursement with the insurance company lies with the client.

6. CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, I am unable to make use of that time. Therefore, sessions must be cancelled 24 hours in advance or the $75.00 fee will be charged.

I trust that our time together will be helpful and profitable to you. If you have any questions regarding these arrangements or other aspects of our therapeutic relationship, please ask me at any time.

This is to certify that I have read, understand, and have been given a copy of this document.

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIVACY NOTICE OF

MIKE SORENSON, LPC

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; that is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS May 31, 2017. Mike Sorenson, LPC is required to follow the terms of this Notice until it is replaced. Mike Sorenson, LPC may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. Mike Sorenson, LPC reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which MIKE SORENSON, LPC May Use or Disclose Your Mental Health Information with your Consent

**MIKE SORENSON, LPC may request your consent** for the use and/or disclosure of your *Information* for *treatment*, *payment* or *health care operations* as described below:

 *Treatment*. MIKE SORENSON, LPC may use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. MIKE SORENSON, LPC may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

 *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services.

 *Mental Health Care Operations*. MIKE SORENSON, LPC may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. MIKE SORENSON, LPC may call you by name in the waiting room area. MIKE SORENSON, LPC may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

MIKE SORENSON, LPC may share your *Information* with third party business associates who perform various administrative services. For example, those with whom MIKE SORENSON, LPC contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a business associate and me involves the use or disclosure of your *Information*, I will have a written contract that contains terms that will protect the privacy of your *Information*.

$ *Health Care Services*. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

# Uses and Disclosures With Your Verbal Consent

Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

## Uses and Disclosures with Your Written Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* MIKE SORENSON, LPC maintains, unless MIKE SORENSON, LPC has taken action in reliance on your authorization.

## Uses and Disclosures Without Your Consent

$ As required by law;

$ To comply with legal proceedings, such as a court or administrative order or subpoena;

$ To law enforcement officials for limited law enforcement purposes;

$ To a coroner, medical examiner, or funeral director about a deceased person;

$ To avert a serious threat to your health or safety or the health or safety of others;

$ To a governmental agency authorized to oversee the mental health care system or government programs;

$ To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and

$ To public mental health authorities for public health purposes.

### Your Rights

You may make a written request to me to do one or more of the following concerning your *Information*:

$ Put additional restrictions on use and disclosure of your *Information*.

$ Communicate with you in confidence about your *Information* by a different means than MIKE SORENSON, LPC is currently doing.

$ See and get copies of your *Information*.

$ Receive a list of disclosures of your *Information* that MIKE SORENSON, LPC has made for certain purposes for six (6) years prior to your request, with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, MIKE SORENSON, LPC is not required to agree to your request. MIKE SORENSON, LPC will give you the necessary information and forms for you to complete and return to request your *Information*. MIKE SORENSON, LPC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)

Complaints

If you believe that MIKE SORENSON, LPC violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. MIKE SORENSON, LPC will not retaliate against you if you choose to file a complaint.

Contact Address:

Mike Sorenson, LPC

1500 SE King Dr.

Bartlesville, OK 74006

PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Mike Sorenson, LPC, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Mike Sorenson, LPC.

Client Name or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Mike Sorenson, LPC

**Financial and Scheduling Policy/Agreement**

**Financial:**

* Payment is expected at the time service is rendered. I accept cash or check, made payable to Mike Sorenson, LPC. If you choose to pay by check for counseling services, please be prepared to supply a form of ID, such as a driver’s license.
* Receipts can be provided upon request

**Scheduling:**

Normally, I schedule clients into a particular time slot, which is either a weekly or every other week time slot.

If you fail to give 24 hours notice in cancelling a scheduled appointment, I will still charge the $75 fee for the missed session

If you cancel scheduled appointments more than 3 times in a 6-month time period (even if you gave appropriate notice), I reserve the right to open up that regular time slot to another client.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the Financial/Scheduling Policy in its entirety and agree to it.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent For Treatment of a Minor

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give Mike Sorenson, LPC permission to provide treatment for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

# Confidentiality Statement

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand limits to confidentiality and have

 parent child

 been provided with a copy of this statement.

 **For the Parent/Guardian:** The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others, including your child.

 **For the Child:** The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others.
3. The professional has reason to believe that someone or something is harming you including your parents.

**Additional Disclosures at the Parent’s Request**:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

Therapist Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child