Welcome to Groundwork Counseling Services LLC. Prior to your first appointment, we invite you to review the following important information regarding our services and practices. Please note any questions that you have in reading through the following information so that we may discuss them further. Signing this form will represent an agreement between us and acknowledge that you feel adequately informed regarding the services and support you receive during your time in counseling.

**Therapy, Counseling & Coaching Services**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy, counseling, and coaching can have benefits and risks. Since therapy often involves discussing difficult or challenging aspects of your life or past, you may find yourself (or your child) experiencing intense emotions while in therapy. On the other hand, therapy, counseling and coaching has shown to be significantly beneficial to those who participate in it. Therapy can often assist individuals to find solutions to problems, improve self-image, reduce negative feelings, and improve relationship quality. There are no guarantees of what you will experience.

If at any time during our counseling relationship you would like more information regarding therapeutic interventions, education, or general information please do not hesitate to ask.

**Assessment & Sessions**

Our first few sessions will include an evaluation and assessment of your needs (or your child’s needs). After several sessions, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. Each session is scheduled for 60 minutes in length, unless the client (or parent) has requested a 90-minute session (additional fee). Frequency of visitation will be mutually agreed upon as part of your plan of care.

**Cancelation Policy**

Once an appointment is scheduled any client will be required to pay for that appointment at the fee set for the length or purpose of the appointment unless 1 full business day notice is provided (a Monday morning appointment must be cancelled by Friday morning). Cancellations with less than 24 hours notice will be charged the full session fee. I do understand that circumstances beyond an individual’s control can arise - in specific cases the fee may be waived at the counselor’s discretion. Excessive missing of appointments, whether paid or unpaid, will result in a reevaluation of our contract and your continuation in therapy. I reserve the right to terminate the counseling relationship in the event that 2 consecutive appointments are missed without notification of cancelation. Please note that consistency in counseling, and attending each session will provide you with the optimum potential to benefit from your therapeutic experience.

**Online Counseling Service Fees (For All Counseling Appointments)**

- 60 Minute Individual Session: $100
- 90 Individual Session: $150
In addition to weekly appointments, I charge this amount for other professional services you may request. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized and requested, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350 per hour for preparation and attendance at any legal proceeding. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment, pro-bono services, or a payment installment plan.

Payment
Cash, checks, and all credit cards are accepted. A credit card must be on-file with release to auto-bill for your appointment if an appointment is missed without 24 hours notice. Also, auto-billing can be utilized for each appointment if it is more convenient for you.

Insurance
At this time I do not reimburse through insurance. You may attempt third party reimbursement; I am happy to supply a bill for you to submit to your insurance provider, however, I do not guarantee reimbursement. Please be aware that if you request a summary or bill to submit to your insurance provider, it is likely that your insurance company will require you to authorize your therapist to provide them with a clinical diagnosis. In other cases, they may request additional clinical information such as treatment plans or summaries.

Contacting Your Therapist & Office Hours
I am not often immediately available by telephone. While I maintain office hours (by appointment only), I am often with clients and unable to answer the phone. When I am unavailable, your call will be answered by my voicemail, which I monitor frequently. I will make every effort to return your call within one business day, with the exception of weekends and holidays. If you do not hear back from me in that time frame please call back as it may mean that your message was not retained by my voicemail. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can’t wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Qualifications
At Groundwork Counseling, we offer counseling services from licensed mental health counselors, (LMHC) licensed marriage and family therapists (LMFT), and registered mental health counseling interns (RMHCI). Licensed Mental Health Counselors (LMHC) and Licensed Marriage and Family Therapists (LMFT) hold a master’s degree in marriage and family counseling, or clinical mental health counseling, and are fully licensed with the state of Florida and hold an active license with the state of Florida, Registered Mental Health Counseling Interns (RMHCI / IMH) hold a master’s degree in marriage and family counseling, or clinical mental health counseling and are registered in the state of Florida as a counseling intern seeking state licensure – these individuals have completed over 1000 hours of clinical counseling practicum and internship experience, and practice under the supervision of a licensed counselor. All license and registration numbers as well as supervisor contact information are available by request; please ask your counselor if you have any questions regarding their credentials, education, or Florida state registration or license numbers, we’d be happy to supply them to you.

Professional Records
The laws and standards of my profession require that counselors keep treatment records of each session. This information can be requested in writing and will be provided to clients either in full or in summary. This information is maintained in clinical language and is subject to misinterpretation and as a result could be upsetting. If I believe this information is subject to high levels of misinterpretation I may offer to review the records with you during a scheduled session. Because these records contain sensitive information I strongly suggest patients reviewing them with a mental health provider.
I utilize a “paperless” approach to record keeping. Your files will be stored on a HIPPA approved, secured and password protected cloud-based software. Any hardcopy files will either be filed in accordance with HIPPA / ACA guidelines or scanned into the database and shredded.

Information contained in email and text messages may be privileged and confidential. However, there is some risk that any information that may be contained in such email or text message may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email and text communication can be intercepted in transmission or misdirected. Your use of email or text to communicate information indicates that you acknowledge and accept the possible risks associated with such communication.

**Minors**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. I request for parents to not examine child or adolescent records, or request a summary without the minor’s consent. Before giving parents any information, I will discuss the matter with the client, if possible, and do my best to handle any objections the client may have.

**Confidentiality**

In general, the privacy of all communications between a patient and counselor is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient’s treatment. For example, if I believe that a child [elderly person, or disabled person] is being abused, I am required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our initial meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

**SPECIFIC TO DISTANCE COUNSELING**

**Terms & Conditions for Online Counseling**

Clients interested in receiving online counseling services must be at least 18 years-old.

Clients interested in online counseling services must consult with a GroundWork Counseling provider to discuss eligibility as well as the terms and conditions that apply to said services. If it is determined that online counseling is appropriate, clients must submit written verification (indicated by their signature) to the terms and conditions (see below) before services are rendered.

**Eligibility for Online Counseling Services**

Online counseling services are not meant to take the place of direct, face-to-face psychotherapy services.

Online counseling services are most suitable for clients over the age of 18 years-old who have either previously engaged in formal counseling services and/or are seeking short-term support for issues that are unrelated to major crisis, severe mental health issues, suicidal, homicidal or violent behavior (past and present).

Online counseling services are intended for clients who have limited access, availability or financial means to receive direct, face-to-face professional counseling services.
Although online counseling services may be helpful, direct, face-to-face services are highly recommended and encouraged, especially for clients either looking for long-term treatment or clients in major crisis.

Online counseling does not provide crisis counseling and is not intended for clients who:
Have a history of major psychiatric episodes, hospitalizations or drug/alcohol dependence.
Have been diagnosed as any of the following - Borderline Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type 1, Mentally III/Chemically Addicted (MICA), and/or Schizophrenia.
Have a history of suicidal, homicidal or violent behavior or present as suicidal, homicidal or violent.

**Full Client Disclosure & Right to Refuse Online Counseling Services**
If you have any history of major psychiatric episodes, hospitalizations or drug/alcohol dependence or have been diagnosed as any of the following - Borderline Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type 1, Mentally III/Chemically Addicted (MICA), and/or Schizophrenia - **you must disclose this information to your GroundWork Counseling counselor prior to being considered for online counseling services.**
Failure to do so or knowingly misleading or withholding the above said information excludes GroundWork Counseling LLC, from any legal obligation or liability related to said client’s diagnosis, prognosis, outcome and actions.
If it is deemed at any point in the treatment that your needs are greater than your counselor’s area of expertise or scope of practice and a client is unsuitable for online counseling services, your counseling provider reserves the right to refuse and/or end treatment and appropriate referral sources will be provided.

**About Distance Counseling**
Also known as Telepractice, Cyberpsychology, Text-Based Therapy, Telehealth, Behavioral Telehealth, and Online Therapy. Distance counseling is providing a psychotherapy service that is not “in person” and is facilitated through the use of technology. Such technology may include, but is not limited to, telephone, telefax, email, internet, or videoconference. Distance Counseling is subject to all practice and ethical considerations discussed in this document and in the law, rules and regulations governing licensed practice in Florida.
Disadvantages include varying time zones, cultural differences, language barriers, and strength of internet connection which may impact the delivery of services. Clients may provide off-line contact information in case of a technology breakdown.

**Scope of Practice**
This term indicates the specific area to which a practitioner may practice. GroundWork Counseling providers follow local and regional laws and codes of ethics as applicable to a client’s geographic location.
According to national licensure requirements, your provider is permitted to provide counseling services in all states excluding: Arkansas and Nebraska, which issue geographical boundaries for distance counseling and require practitioners to be licensed by that state.

**Nature of Counseling**
There may be both benefits and risks while participating in counseling, distance or otherwise. Counseling may improve your ability to relate with others, provide a clearer understanding of yourself, your values, and your goals. Since counseling may also involve discussing unpleasant aspects of your life, you may also experience uncomfortable feelings. Counseling often leads to better relationships, solutions to specific problems, and significant improvement in feelings of distress.
However, please understand there are no guarantees of what you will experience, and that you enter this Agreement and use GroundWork Counseling LLC services at your own risk. You agree that you understand the possible advantages and disadvantages of online/distance therapy and shall not hold accountable Groundwork Counseling for any information or insight distributed here.

**Agreement**
This Agreement shall be interpreted only in accordance with the laws of the Florida state laws (excluding any rules governing choice of laws), and any legal proceeding associated with this Agreement will occur exclusively in the courts located in Florida.
Privacy Policy
According to mental health licensing statutes, the law protects the privacy of all communications between a client and practitioner. Groundwork Counseling LLC is in compliance with the requirements of HIPPA. Confidentiality is taken seriously and discussing or releasing your information to any individual, agency, or corporation except if such release is requested by a signed authorization form (located in this information packet) or if a client indicates intent to do harm to her/himself or others.

Limits of Confidentiality
There are some situations in which practitioners are legally and ethically obligated to take actions they believe may be necessary to protect a client or others from harm. If such a situation arises, your counselor will make every effort to fully discuss the issue with the client before taking any action and will limit disclosure to only what is necessary.
If a practitioner has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
If a client presents a clear and substantial danger of harm to himself/herself or others, your counselor is ethically obligated to take protective actions.
These actions may include contacting family members, assisting with hospitalization, notifying any potential victim(s), and notifying the police.

If you are considering suicide, or believe yourself to be a potential safety threat to others, you must immediately call 911, (800) LIFE-NET and/or notify the police and/or seek emergency care at your local hospital.

Additionally, your counselor will file a formal report if potential online clients states any desire to do harm to him/herself or others.

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

____________________________________                   ____________  
Client / Legal Guardian                      Date

____________________________________  __________________
Counselor                                      Date

Revised 12/13
Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU IS PROTECTED AND MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. Confidentiality

As a rule, I will not disclose information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, a diagnosis if applicable, functional status, symptoms, prognosis and progress, and any assessment tools administered or obtained. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, I require that you sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Abuse Hotline at 1-800-96-ABUSE.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Abuse Hotline at 1-800-96-ABUSE.
- **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you. If there is a criminal or civil case being pursued or considered I ask that you advise me as this makes records more subject to being requested and may have an effect on your response to therapeutic services provided.
- **Serious Risk to Health or Safety to Self:** Under Florida law, if I am engaged in my professional duties and you indicate an intent and verbalize means to bring harm to yourself I am required to take steps to ensure your safety. If you indicate an intent and verbalize means to complete or attempt a suicidal gesture I am required to take steps to ensure your safety. For both of these instances voluntary or involuntary hospitalization will be utilized and Baker Act procedures initiated to minimize the likelihood that you will be able to bring harm or fatal injury upon yourself.
- **Serious Risk to Health or Safety to Others:** Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to inform the third, or threatened party. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. I may also use and disclose medical information about you when necessary to prevent
an immediate, serious threat to your own health and safety.

- Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

- Records of Minors: Florida law limits the confidentiality of the records of minors. For example, parents may not be denied access to their child's records. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

II. Patient’s Rights and Providers Duties:

- Right to request restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request but will do my best to disclose the minimum necessary information. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

- Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice).

- Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

- Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

- Right to a Copy of This Notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the change notice effective for medical information I already have about you as well as any information I receive in the future. If there are changes a new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

- Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you may submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services or visit their website at www.hhs.gov.

### Patient’s Acknowledgment of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgment form. You have been provided a copy of the Notice of Privacy Practices of GroundWork Counseling LLC. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: __________________________________________________________

Printed Name: _______________________________________________________

Date: ________________
Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THE AUTHORIZATION AND BRING IT WITH YOU TO YOUR APPOINTMENT. WE REQUIRE ALL ACTIVE CLIENTS TO HAVE A CREDIT CARD ON FILE.

All information will remain confidential.

Cardholder Name: ___________________________________________

Billing Address: ___________________________________________

_______________________________________________________________________________

Credit Card Type: _____ Visa   _____ Mastercard   ____ Discover   _____ AmEx

Credit Card Number: ___________________________________________

Expiration Date: ___________________________________________

Card Identification Number (last 3 digits located on the back of the credit card): _________

Charge this card automatically for appointments? (Please circle one of the following)

YES (Always, for all appointments)

SOMETIMES (If I do not have a check or cash)

NO (I will be paying with cash or check – only use this card for missed appointments without 24hr notice)

I authorize GroundWork Counseling LLC to charge the agreed service charge to my credit card provided herein. I understand my card will be charged the full service fee for missed appointments if 24 hours notice is not given. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name: ___________________________________________

Signed: ___________________________________________

Dated: ___________________________________________
(This form is optional - please only fill out this form if you would like to give us permission to communicate with your doctor, psychiatrist, school, other mental health care practitioner, or a family member that is not a parent or legal guardian.)

CONFIDENTIAL RELEASE OF INFORMATION

I ___________________________ hereby authorize GroundWork Counseling LLC to release to:

______________________________________________________________________________
Name and title

______________________________________________________________________________
Address City State Zip Code

______________________________________________________________________________
Phone number and/or Fax number, including area code

Information regarding services received for the purpose of:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name: _____________________________________________________ (please print)
Signature: ___________________________________________ Date: ___________

Current Address: ____________________________________________
Phone Number: ____________________________________________
Email Address: _________________________________

This consent is valid until ____________ (six months maximum before a new release form is signed) (please specify date)

I understand that I may only revoke this form by notifying, in writing, the person, department or office authorized by this form to release information. I further understand that, after this date, I will need to sign a new release form should I wish to continue to authorize the release of information.

For more information, or if you have questions or need clarification, please contact your GroundWork Counseling provider.
Adult Intake Form

Name: _____________________________________ D.O.B: _______________ Age:____________
Today’s Date: ________________________________

How did you hear about us / referred by: (please select one)
Pediatrician __ Google Search __ Theravive __ Psychology Today __ Word of Mouth/Friend __
Other __ Please indicate____________________

Address:_____________________________________________________________________________

Home Phone:_____________________________ May I contact you at your home? YES NO
Cell Phone: _____________________________ May I contact your cell phone? YES NO

May I text your above cell phone? YES NO
E-mail Address:___________________________ May I contact you via email? YES NO

Preferred Method of Contact:______________________________

*Please note: Email correspondence and texting is not considered to be a confidential medium of communication.

Marital Status

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Number of Marriages________

Please list any/all children and their age:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: ________________________________

Are you currently taking any prescription medication? □ Yes □ No

Please list:

________________________________________________________________________________________

________________________________________________________________________________________

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates and medications previously prescribed:
General Health & Mental Health Information

How would you rate your current physical health? (please circle)
Poor    Unsatisfactory    Satisfactory    Good    Very good

Please list any specific health problems you are currently experiencing:

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

If Applicable (Women)

Number of Pregnancies_____  Number of Children:_______

Do you have regular monthly periods?  □ No  □ Yes

How would you rate your current sleeping habits? (please circle)
Poor    Unsatisfactory    Satisfactory    Good    Very good

Please list any specific sleep problems you are currently experiencing:

_________________________________________________________________________________________
_________________________________________________________________________________________

How many times per week do you generally exercise? _________________________

What types of exercise do you participate in:

_________________________________________________________________________________________
_________________________________________________________________________________________
Do you currently or have you ever had problems with eating or with food? □ No □ Yes
If yes, please describe:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Do you have any concerns related to your weight and/or physical appearance? □ No □ Yes
If yes, please describe:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please list any difficulties you experience with your appetite or eating patterns.
________________________________________________________________________________________
________________________________________________________________________________________

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? ________________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this?
________________________________________________________________________________________
________________________________________________________________________________________

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Do you drink alcohol? □ No □ Yes  Frequency:_________
Do you engage recreational drug use? □ No □ Yes Frequency:_______

Are you currently having, or have you ever had any problems related to money, spending, shopping, gambling, credit cards or finances? If so, please describe:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? ________________
On a scale of 1-10, how would you rate your relationship? ____

Have any aspects of your sexuality ever been a cause of concern for you? □ No □ Yes
If so, please describe:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What significant life changes or stressful events have you experienced recently:

____________________________________________________________________
____________________________________________________________________

____________________________________________________________________

_________________________

____________________________________________________________________

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

List Family Member:

Alcohol/Substance Abuse __________________________

Anxiety __________________________

Depression __________________________

Domestic Violence __________________________
| Eating Disorders   | _____________________________ |
| Obesity           | _____________________________ |
| Obsessive          | _____________________________ |
| Compulsive Behavior| _____________________________ |
| Schizophrenia     | _____________________________ |
| Suicide Attempts  | _____________________________ |
| Other             | _____________________________ |

**Additional Information**

Are you currently employed? □ No □ Yes

Place of employment: _____________________________

Do you enjoy your work? Is there anything stressful about your current work?
__________________________________________________________________________________________
__________________________________________________________________________________________

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
__________________________________________________________________________________________
__________________________________________________________________________________________

What do you consider to be some of your strengths:
__________________________________________________________________________________________
__________________________________________________________________________________________

What do you consider to be some of your weakness?
__________________________________________________________________________________________
__________________________________________________________________________________________

What would you like to accomplish out of your time in therapy?
__________________________________________________________________________________________
__________________________________________________________________________________________
Please list any information you deem to be important for the therapist to know:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Thank you for taking the time to fill out the client intake documents. Please sign and date below.

______________________________________ ______________
Individual Completing The Form Date

_____________________________________
Signature

______________________________________ ______________
Counselor Name & Credential Date

_____________________________________
Counselor Signature