Peaceful Mind
COUNSELING SERVICES

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INTAKE FORM

Welcome to my counseling practice. Please provide the following information and answer the questions below. Please note: The information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Client Name: _____
(Last) (First) (Middle Initial)

Name(s) of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Phone: (_____) _____-_____ May we leave a message? ☐Yes ☐No

Cell/Other Phone: (_____) _____-_____ May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

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

Client Address (1):

Street: _____

City-State-Zip: _____

Telephone: _____Persons living in home: _____

Client Address (2):

Street: _____

City-State-Zip: _____

Telephone: _____Persons living in home: _____

School: _____ Telephone: _____

Place of Employment (client): _____ Telephone: _____

Place of Employment (mother/if under 18): _____ Telephone: _____

Place of Employment (father/if under 18): _____ Telephone: _____

In Case of Emergency

Contact Person: _____ Telephone: _____

Referred by (if any): _____

Do I have your permission to contact them to thank them, using your name? _____

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TREATMENT HISTORY

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

☐ No ☐ Yes, previous therapist/practitioner: _____

When and how long? _____

Have you ever been hospitalized for a psychiatric condition? ☐ No ☐ Yes

If yes, describe date(s) and circumstances: _____

_____

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

Please list: _____

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

Please list and provide dates of past and current, along with the prescriber names: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

_____

2. 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:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

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

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this, and what symptoms do you have? _____

_____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

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9. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. 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? _____

PRESENTING CONCERNS

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please check the number indicating the degree to which each item is *presently a concern for you.*

	Not at all	A little bit	Quite a bit	Extremely
	1	2	3	4
1. Dealing with stress or pressure	1 ☐	2 ☐	3 ☐	4☐
2. Feeling sad, depressed or down	1 ☐	2 ☐	3 ☐	4☐
3. Death or illness of a significant person	1 ☐	2 ☐	3 ☐	4☐
4. Difficulties related to sexual orientation/identity	1 ☐	2 ☐	3 ☐	4☐
5. Family relationships	1 ☐	2 ☐	3 ☐	4☐
6. Abuse in relationship with partner/family member	1 ☐	2 ☐	3 ☐	4☐
7. Feeling anxious, worried, or panicky	1 ☐	2 ☐	3 ☐	4☐
8. Feeling unmotivated, difficulty concentrating	1 ☐	2 ☐	3 ☐	4☐
9. Feeling irritable, tense, angry, or hostile	1 ☐	2 ☐	3 ☐	4☐
10. Money or finances	1 ☐	2 ☐	3 ☐	4☐
11. Feeling isolated and uncomfortable with others	1 ☐	2 ☐	3 ☐	4☐
12. Values, beliefs, or spirituality concerns	1 ☐	2 ☐	3 ☐	4☐
13. Sexual abuse in childhood	1 ☐	2 ☐	3 ☐	4☐
14. Physical or verbal abuse in childhood	1 ☐	2 ☐	3 ☐	4☐
15. Someone else's habits or behaviors	1 ☐	2 ☐	3 ☐	4☐
16. My own unwanted habits or behaviors	1 ☐	2 ☐	3 ☐	4☐
17. Rape, sexual assault, or sexual harassment	1 ☐	2 ☐	3 ☐	4☐
18. Eating concerns (i.e., bingeing, restricting, vomiting, laxative use, etc.)	1 ☐	2 ☐	3 ☐	4☐
19. Weight or body image concerns	1 ☐	2 ☐	3 ☐	4☐
20. Problems with partner/spouse/family member	1 ☐	2 ☐	3 ☐	4☐
21. Sexual concerns (i.e., pregnancy, sexual functioning, sexually transmitted disease, etc.)	1 ☐	2 ☐	3 ☐	4☐
22. Physical health problems	1 ☐	2 ☐	3 ☐	4☐
23. Urge to harm others	1 ☐	2 ☐	3 ☐	4☐
24. Concerns about my own drug or alcohol use	1 ☐	2 ☐	3 ☐	4☐
25. Thoughts of harming myself	1 ☐	2 ☐	3 ☐	4☐
26. Other (please explain):	1 ☐	2 ☐	3 ☐	4☐

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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.).

	Please Check	List Family Member(s)
Alcohol/Substance Abuse	☐ No ☐ Yes	_____
Anxiety	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	_____
Domestic Violence	☐ No ☐ Yes	_____
Eating Disorders	☐ No ☐ Yes	_____
Obesity	☐ No ☐ Yes	_____
Obsessive Compulsive Behavior	☐ No ☐ Yes	_____
Schizophrenia	☐ No ☐ Yes	_____
Suicide Attempts	☐ No ☐ Yes	_____

ADDITIONAL INFORMATION

1. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
   If yes, describe your faith or belief: _____

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3. What do you consider to be some of your strengths? _____
   _____
   _____

4. What do you consider to be some of your weakness? _____
   _____
   _____

5. What would you like to accomplish out of your time in therapy? _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

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LIMITS OF CONFIDENTIALITY

The Code of Ethics of the National Association of Social Workers and the laws of the State of Arizona ensure the conversations you have with a therapist will be held in strict confidence. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, there are a few exceptions when therapists are legally bound to share information given in confidence under the following circumstances:

Duty to Warn and Protect

1. When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities.
2. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
3. Abuse of Children and Vulnerable Adults. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
4. Prenatal Exposure to Controlled Substances. Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Companies (when applicable): In the event that an insurance company requests information other than on the claim form, this office will provide only a summary, with your written permission. Copies of progress notes from your confidential file will not be released. Most insurance companies require a diagnosis in order to pay for services.

Confidentiality Regarding the Treatment of Minors (under the age of 18):
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records by submitting a written request. However, Parents are encouraged to respect their child's right to privacy and confidentiality; therefore the specifics of the therapy conversations with the child will be kept confidential. Parents can be assured that their child will be encouraged to share critical information and feelings with them. Additionally, parents will be given information about general issues at hand as well as a clear summary of treatment.

I agree to the above limits of confidentiality and understand their meanings and ramifications. I agree to have myself/son/daughter participate in treatment.

_____
Client Signature

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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FEE POLICY AND AGREEMENT

I am committed to providing the most effective and efficient social work treatment and services possible. To do so, I need your understanding of our fee policy and the reasoning behind it, as well as your cooperation.

PAYMENTS

I understand that I am responsible for providing payment to Peaceful Mind Counseling Services the time services are rendered. Outstanding balances should be paid in full prior to the next scheduled session, unless alternative arrangements for payment have been made with consent of Peaceful Mind Counseling Services. You will be given a receipt after each session upon request. If you have a health plan, you will need to forward a copy of this receipt to your insurance company in order to be reimbursed. It is advised that you call your insurance company to inquire about additional documentation that may be required for reimbursement. In all cases, however, payment for services is ultimately the responsibility of the client, not the insurance company. Returned checks are subject to a $25 charge and balances over 60 days that require collections are subject to all collection fees.

Accepted forms of payment are **cash, credit, and check.** There will be a fee of $25 for all returned checks. I understand that Peaceful Mind Counseling Services has the right to send unpaid balances over 60 days to a collections agency, unless alternative payments arrangements have been made. (Initial) _____

FEES FOR SERVICE

	Office Location	In-Home/Community Based
Brief Initial phone consultation	no fee	n/a
Initial consultation (1 hr)	$125	$150
Individual/Family Therapy (50 min)	$125/$150	$150/$175
Individual/Family Therapy (90 min)	$150/$175	$175/$200
Late Cancellation/No Show	$125	$150

I reserve the right to change my fees with 30 days notice. You have the right to be informed of all fees that you are required to pay and my refund and collection policies. Please discuss these with me if you have a concern.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. If you call on a weekend, leave a voicemail message at (480) 424-4777. If transportation problems develop, I will consider a telephone session in order to make use of my time reserved.

This policy is not meant to penalize you, rather to maintain quality in my work by not overbooking clients. It is also meant to encourage the hesitant person to come and utilize therapy, even when feeling anxious or depressed.
Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I am committed to meeting you where you are in your journey and support you in discovering where you would like to grow or heal. Counseling offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

UNDERSTANDING TREATMENT

The therapeutic services at this office consist of a series of conversations between you and your therapist. These conversations are intended to assist you to discover and use your personal resources to more adequately meet life's demands. Sometimes these discoveries can temporarily increase your stress level, affecting your work, school, or relationships. Therapy can also assist in reducing this stress.

Therapy is for your benefit so please ask questions about any techniques or therapeutic procedures. You have the right to an established set of treatment goals that are regularly reviewed. You may stop treatment at any time without any moral or legal obligation.

BACKGROUND AND SERVICES

As a Licensed Clinical Social Worker, I provide an interactive treatment experience to help clients address concerns and life issues. I blend therapeutic approaches and techniques to formulate a style which best meet your particular need, while providing support and practical feedback. Because we are all unique in our own ways, we all thrive in a balance of healing styles. I will work closely with you to determine what style works best for you or your child/teen. My personalized approach will help us develop an individualized, strengths-based treatment plan that will help you attain personal goals and recovery.

RIGHT TO REFUSE TREATMENT

In order to be mindful of the best therapeutic experience for each client, I also understand clients may need different therapeutic approaches. If client therapeutic needs are not a good match for my skills or experience, I reserve the right to refer a client to another therapist or appropriate resource. I have the right to discontinue treatment at any time or withdraw this consent by notifying Peaceful Mind Counseling Services. If it is determines that you need additional or specialized treatment that Peaceful Mind Counseling Services cannot provide, alternatives will be provided. Peaceful Mind Counseling Services will not be responsible for the cost or outcome of treatment sought elsewhere.

AVAILABILITY OF SERVICES

My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines:
Empact Suicide Prevention Center. 24 Hour Crisis Hotline – 480-784-1500, Teen Lifeline 1-800-631-1314
Maricopa 24 Hour Crisis Hotline 602-222-9444, Across Arizona 1-800-252-6465

PHONE CALLS BETWEEN SESSIONS

Brief telephone calls in which you advise us of a schedule change or ask for a specific piece of information are encouraged. Established clients with an urgent need to make contact may call me, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation. If the concern is regarding something significant, you may want to schedule an appointment. In

addition, please allow 24 hours for non-emergency phone calls to be returned. Please note that, with the exception of the initial paperwork, there will be no communication via e-mail.

Please note that Peaceful Mind Counseling Services does not conduct therapy over the telephone on a regular basis and if your concern is regarding something significant, you will need to schedule an appointment. More extensive conversations will be charged as an office visit.

APPOINTMENTS

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an 50 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. Late cancellations or missed appointments will be billed at the full fee and repeated cancelations may result in termination of treatment.

Appointment availability varies with the client load at the time. High demand appointments (late afternoons, evenings) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

PRIVACY, CONFIDENTIALITY AND RECORDS

Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statute. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods. There are also numerous other circumstances when information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. The HIPAA NOTICE OF PRIVACY PRACTICES, included in this packet of information, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

I have read the HIPAA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPAA NOTICE OF PRIVACY PRACTICES is incorporated by reference into this agreement. _____ Initials

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PURPOSE, LIMITATIONS, AND RISKS OF TREATMENT

Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

TREATMENT PROGRESS AND RIGHTS

Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

OUR RELATIONSHIP

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained. If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

TERMINATION POLICY AND PROCEDURE

1. Clients may terminate treatment at any time.
2. Peaceful Mind Counseling Services may terminate treatment for the following reasons:
a. Therese Hensler, MSW, LCSW determines that she does not have the expertise to treat the client's problems.
b. Therese Hensler, MSW, LCSW determines that the client needs a higher level of care and she doesn't provide the scope of services needed for the client.
c. The client is failing to adhere to the treatment plan – i.e. failure to notify the provider of significant changes in condition, two or more no-shows or cancellations (with our without 24 hours-notice) consecutively for scheduled appointments, or multiple appointment cancellations that result in significant periods without treatment.
d. Failure to pay outstanding charges on client account or failure to pay for services to include no show fees.
e. Inappropriate behavior (e.g., threats, derogatory language, and/or not limited to any disruption to the practice).
3. If the practice terminates care, the client will be provided written notice including the reasons for the termination and referrals for alternative sources of treatment (if, in the opinion of the provider, the client would benefit from some further treatment). Notice period will be 30 days UNLESS termination is due to non-adherence with the treatment plan or inappropriate behavior, in which case the client will be considered to have violated the treatment contract and waived the notice period.

4. If a client's treatment has been terminated for any of the reasons listed above, the client's record will not be reopened in the future for any reason, unless authorized by Therese Hensler, MSW, LCSW.

CONSENT FOR EVALUATION AND TREATMENT

Consent is hereby given for evaluation and treatment under the terms described in this consent document and the HIPAA NOTICE OF PRIVACY PRACTICES. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Thank you for taking the time to complete this form. Information is kept confidential.

Signature: _____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor: _____ DOB _____ Relationship: _____

For office use only - verification that client has read and understands informed consent document
Authorized Representative: _____ Date: _____