Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Personal Information

Name:____ Date: ______________________

Parent/Legal Guardian (if under 18): ____

If yes, please explain: ____

Address: ____

Home Phone: ___________________________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: __________________________ May we leave a message? □ Yes □ No

Email: ____ May we leave a message? □ Yes □ No

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

DOB: ______________________________ Age: _______ Gender: ________________

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any): ____

History

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

If yes, please list:

____

____

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

If yes, please list and provide dates:

____

____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

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 one)

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 do you participate in? ____

4. Please list any difficulties you experience with your appetite or eating problems: ________________

____

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

If yes, for approximately how long?____

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

If yes, when did you begin experiencing this? ____

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

9. How often do you engage in 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 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

____

11. 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 (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_______________________
Anxiety	yes / no	_______________________
Depression	yes / no	_______________________
Domestic Violence	yes / no	_______________________
Eating Disorders	yes / no	_______________________
Obesity	yes / no	_______________________
Obsessive Compulsive Behavior	yes / no	_______________________
Schizophrenia	yes / no	_______________________
Suicide Attempts	yes / no	_______________________

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? ____

____

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

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: ____

____

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

____

____

4. What do you consider to be some of your weaknesses? ______________________________________

____

____

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

____

____

Disclosure Statement

Brittany Junker

Mental Health Counselor Intern

Training and professional background:

Brittany Miller has a master's degree in Clinical Mental Health Counseling from Hodge's University in Fort Myers Florida. Brittany is a Registered Mental Health Counselor Intern with the State of Florida. She is under the direct supervision of Rebecca Sherry who is a Licensed Mental Health Counselor in the State of Florida#(MH12994). She has experience working with Adults and Children experienced trauma, anxiety, depression, ADHD, conduct disorder, relationship and/or family conflict, domestic violence, sexual violence, self-esteem, mood disorder and grief.

Theoretical orientation and approach to counseling:

Brittany's clinical approach to counseling includes Solution-Focused Brief Therapy, Acceptance and Commitment Therapy, Cognitive Behavioral Therapy, Compassion-Focused Therapy, Emotion-Focused Therapy, Guided Therapeutic Therapy, Holistic Psychology, and Mindfulness-Based Therapy.

The right of clients in counseling:

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

Brittany Miller is bound by the ethical codes of her of her respective professional organizations, by the laws of the State of Florida, as well as by agency policy regarding the special nature of a therapist-client relationship. It is expected that the counselor will continue to be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her counselor is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the counselor.

Confidentiality:

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside of this office, and only then, with a release signed by the client. Interns work closely with their supervisor Janean Byrne and will frequently discuss client case details to assure proper therapeutic gains. The counselor may be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life sustaining self-care. In these situations, the counselor is required to take steps necessary to secure the safety of the client or others.

My signature below acknowledges that I a m the legal guardian of ____________________and have received and understand the Disclosure Statement; thus, consenting to their participation in counseling services at Serenity Counseling Center.

Client (or legal guardian's) signature(s) ____ Date __________

Spouse (or other parent) signature ____ Date __________

Mental Health Counselor Intern's Signature ____________________________________ Date __________

Serenity Counseling Center

Patient Treatment Agreement

Welcome to Serenity Counseling Center. We would like to ensure you that you will receive the best possible care from our professional staff.

Payment: Due at the time that the service is provided. We accept credit or debit cards. A 3% fee will be applied to credit or debit transactions. The fee for a 50-minute session is $90.00. As a client, you are agreeing to pay <u>$90</u> at the end of each session.

Cancelations: If you are unable to keep your scheduled appointment, you must notify your counselor 24 hours prior to your appointment or you will be charged a $50.00 cancellation fee. You are giving Serenity Counseling Center permission to contact you via phone call, text or email concerning your appointment, case information or other business pertaining to Serenity Counseling Center.

Legal: Our counselors are available for in-office depositions at an agreed upon fee. The counselors are not available, nor will appear in court for testimony regarding a case unless arrangements are made outside of and prior to this initial agreement. By signing you agree that this information has been formally conveyed.

"I, the undersigned, agree to treatment by the providers in this office, and furthermore have read and understand the above policies".

Client Name: ____ Date: ______________________

Client Signature: ____ Date: ______________________

Serenity Counseling Center

Informed Consent for Telehealth Services

I understand that "telehealth" can include secure videoconferencing or other interactive audio, video, or data communications.

In addition, telephone calls or psychoeducation via email may be a reasonable option during this temporary expansion of services.

The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential by my service provider (Serenity Counseling Center), however, because telehealth occurs outside of the therapist's office, I understand I am responsible for taking steps to ensure confidentiality of the sessions in my location by – 1) engaging in telehealth sessions when I am in a private location and have made every effort to maintain my own privacy in that location, and 2) and agreeing not to record any telehealth session or portion of a telehealth session. 4. I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons. 5.

I understand that I am responsible for the following: - providing the computer and/or necessary telecommunications equipment and internet or phone access for telehealth sessions. - arranging for a location with appropriate lighting, sound, or other characteristics that will allow telehealth sessions to proceed effectively. I understand that I may benefit from telehealth sessions but that results cannot be guaranteed or assured. I agree to provide my location to my therapist before the telehealth session begins in the event that my therapist has a grave concern about my wellbeing so s/he/they could initiate a wellness check. I agree to be dressed for any telehealth session as if I were attending an in-person, face-to-face session. I understand that services delivered by my therapist are required by law to take place within the state in which my therapist is licensed, with the exception for crisis consultations or sessions. If I am physically located outside of the state in which my therapist is licensed, I will immediately notify my therapist.

My signature indicates that I have read, understand, and agree to everything above:

Printed Name ____ Date: ____________

Signature ____ Date: ____________