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Your Facts

C1

Counseling Intake Form

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started we need to collect some general information from you.

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Address:_____ **Apartment #:**_____

City:_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____

Email:_____ **Date of Birth:**_____/_____/_____

How did you find us? Patient *(who)*:_____ Doctor *(who)*:_____ Staff *(who)*:_____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other:_____

What is your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Transman/FTM
- ☐ Transgender Female/Transwoman/FTM
- ☐ Gender Queer
- ☐ Additional category:_____
- ☐ Decline to answer

What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Other:_____
- ☐ Decline to answer

Whatpronouns do you prefer?

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Other:_____

Current relationship status:

- ☐ Single
- ☐ Married
- ☐ Civil union
- ☐ Domestic partnership, living together
- ☐ Partnered, not living together
- ☐ Divorced
- ☐ Widowed
- ☐ Commited relationship

Employer:_____ **Work #:**_____ **Ext:**_____

Emergency Contact:_____ **Relationship:**_____ **Phone #:**_____

Do you authorize YOUR EMERGENCY CONTACT to discuss care or treatment with the office in the case of an emergency? ☐ Yes ☐ No

Primary Care Physician (PCP):_____ **Phone #** (PCP):_____

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Your History

C2

First Name: _____ **Last Name:** _____

Mental Health History Status

What problems are you seeking help for? _____

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist? ☐ Yes ☐ No

If yes, when and by whom? _____

Have you ever received counseling or psychotherapy in the past? ☐ Yes ☐ No

If yes, when and by whom? _____

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Your History

C3

First Name: _____ **Last Name:** _____

Medications

Please list any medications you have taken or are taking.

Medications	Date	Side Effects/Benefits

Supplements

Please list any supplements you are currently taking.

Supplements	Date	Side Effects/Benefits

Please Check All That Apply:

- ☐ Depressed mood
- ☐ Lost or gained weight
- ☐ Not enough sleep
- ☐ Too much sleep
- ☐ Sluggish
- ☐ Agitated
- ☐ Never tired
- ☐ Cannot concentrate
- ☐ Afraid to leave home
- ☐ Inflated self esteem
- ☐ Feel guilty or worthless
- ☐ Excessive talking
- ☐ Racing thoughts
- ☐ Easily distracted
- ☐ Over working yourself
- ☐ Impulsive behavior
- ☐ See/hear things that are not real
- ☐ Suspect things may not be real
- ☐ Tense/unable to relax
- ☐ Excessive worry
- ☐ Panic attacks
- ☐ Thoughts of death or suicide
- ☐ Unreasonable fear
- ☐ Fear of social situations
- ☐ Repetitive thoughts/behavior
- ☐ Upsetting memories
- ☐ Recent loss/grief
- ☐ Work/school problems
- ☐ Violent thoughts/behaviors
- ☐ Self harm
- ☐ Anger outburst
- ☐ Careless, high-risk behavior
- ☐ Financial problems

What is your relationship with alcohol? Do you feel you are a normal drinker? ☐ Yes ☐ No

How often do you drink? ☐ Every day ☐ 3-5 times a week ☐ Once a week ☐ Only on weekends ☐ On special occasions

Do you currently use illegal drugs (i.e., marijuana, cocaine, etc..?) ☐ Yes ☐ No

How often do you use illegal drugs? ☐ Every day ☐ 3-5 times a week ☐ Once a week ☐ Only on weekends ☐ On special occasions

List the type of illegal drugs you use: _____

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Your History

C4

First Name: _____ **Last Name:** _____

Additional Notes

Please list any additional notes that you think would be helpful for treatment below: _____

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203 | www.YourWellnessConnection.com

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Consent To Counseling

C5

First Name:_____ **Last Name:**_____

I understand that my child, my family, or myself will be receiving therapy services from **Brittany Lewis, a student intern** who is under supervision of Dr. Michelle Robin, D.C., FASA, CCSP, Founder and CWO, and Crystal Jenkins, LCPC.

Brittany Lewis has completed required education and competencies necessary to be deemed ready to apply his or her clinical skills to working with clients and receives ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and your family members.

By working with a student intern, you receive the benefit of a clinically experienced supervision team assisting in assessment and treatment planning to address your concerns in therapy. In order to provide you the best care, during the pandemic, we require our student interns to meet with our clients virtually, via Zoom.

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

You signature below confirms your informed consent to receiving therapy services from a student intern under supervision and your informed consent to video recordings of therapy sessions.

_____ **(Initial)**

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____ **(Initial)**

I, _____**(client),** do hereby seek and consent to take part in the treatment provided by Brittany Lewis, student intern. If I am attending group services I also understand and consent that confidentiality still applies and Brittany Lewis, student intern is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____ **(Initial)**

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

_____ **(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, Brittany Lewis, student intern is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

Phone: _____ **Email:** _____