Counseling Intake Form

Note: This information is confidential

Demographic Information:

Name: _____ Date: _____

Birth Date/Place_____ Relationship Status: _____

Mailing Address _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we email you? _____

Is it okay to communicate by text message? ___ Yes ___ No Referred by: _____

Preferred Appointment Reminder Method: ___Voice Mail ___Text Message ___Email ___Phone Call

Emergency Contact: _____ Contact Phone: _____

Employer: _____ Work Phone: _____

Please list any children and ages: _____

_____

Highest Grade/Degree _____ Type of Degree: _____

Current Concerns:

Reason for seeking Counseling: _____

When did this begin? (give dates) _____

What do you hope to accomplish in counseling? _____

Behavior – circle any of the following behaviors that apply to you:

Overeating	Sleeping problems	Suicidal thoughts	Procrastination
Temper outbursts	Can't keep a job	Drink too much	Compulsions
Aggressive behavior	Loss of control	Impulsive reactions	Smoking
Phobic avoidance	Lack of Motivation	Crying	Vomiting
Work too hard	Withdrawal	Take drugs	Nervous tics
Concentration difficulties		Take too many risks	

Feelings – circle any of the following feelings that apply to you:

Unhappy	Depressed	Happy	Annoyed	Bored
Angry	Conflicted	Sad	Guilty	Restless
Regretful	Lonely	Anxious	Hopeless	Contented
Fearful	Hopeful	Excited	Panicky	Helpless
Optimistic	Energetic	Relaxed	Tense	Envious
Jealous	Others:			

Tim E. Gusey, LPC, LSSP 105 N. Gordon Street, Suite 202, Alvin, TX 77511 P: 281-585-0000 F: 281-585-0080
tegusey@DowntownCounseling.com

Physical – circle any of the following symptoms that apply to you:

Stomach Trouble	Headaches	Skin Problems	Muscle Spasms
Dizziness	Tics	Dry Mouth	Palpitations
Fatigue	Burning or itchy skin	Twitches	Chest pains
Tension	Back Pain	Rapid heart beat	Sexual disturbances
Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling
Watery eyes	Numbness	Hearing problems	Visual disturbances

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

How many times a week do you generally exercise? _____

What types of exercise do you enjoy? _____

Are you currently experiencing any chronic pain? ____ Yes ____ No

If yes, please describe: _____

How often do you drink alcohol? ___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

How often do you engage in recreational drug use? ___ Daily ___ Weekly ___ Monthly
___ Infrequently ___ Never

Are you currently in a romantic relationship? ___ Yes ___ No

If yes, for how long? _____

On a scale of 1 – 10, how well would you rate your relationship? _____

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

Have you received psychological, psychiatric, or counseling services in the past? ___ Yes ___ No

If yes, what was your concern at the time? _____

If yes, with whom and what was the result? _____

If yes, what diagnosis did you receive? _____

List any psychiatric medications you may have been prescribed. _____

_____

Family Mental Health History – Please circle any of the following that apply:

Alcohol/Substance Abuse	Anxiety	Depression	Bi-polar
Domestic Violence	Suicidality	Temper	
Obsessive Compulsive	Relational Issues	Child Abuse	

Social:

Do you have trusted friends with whom you can share your concerns? _____

How long have you been associated with those you consider to be your closest friends? _____

What do you and your friends like to do together? _____

_____

How would you describe your relationship with your family? _____

_____

What is your involvement in the community? (e.g. volunteering, church, schools, etc)_____

_____

How would you describe your spiritual life? _____

_____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:_____

_____

What are your main worries and fears? _____

_____

What are your most important hopes and dreams for your future? _____

_____

What gives you the most happiness or pleasure in life? _____

_____

_____

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the Client Information packet and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Tim E. Gusey, MA, LPC. I understand that developing a treatment plan and regularly reviewing our work toward meeting 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 in therapy.

I am aware that I may stop my treatment at any time. I will be responsible for paying for any services I have already. I understand that I may lose other services or may have to deal with other concerns if I stop treatment. (For example, if my treatment has been court-ordered, I will answer to the court).

I know that I must call, email, or send a text message to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up for the scheduled appointment, I will be charged a fee of $35.00.

I am aware, that if I choose to use my insurance provider, or other third-party payer, an agent the insurance company may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all these statements.

_____

Signature of client (or person acting for client) Date

_____

Printed name Relationship to client (if necessary)

I, Tim E. Gusey, LPC, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Tim E. Gusey, LPC Date

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care serves to you, to pay your health care bills, to support the operation of the physician's practice, and by any other use required by law. Treatment: We use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from insurance companies. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative

action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may request that any part of your protected health information not be disclosed for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction with you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Heathcare Professional. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from this office, upon request.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by your notification and we will not retaliate against you for filing a complaint. If you have objections to his form, please contact Tim E. Gusey at 281-585-0000 ext. 4.

I have read the notice listed above.

_____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date:

Counselor Limits of Confidentiality

Your counselor recognizes that confidentiality is essential to effective counseling. In order for counseling to work best, you must feel safe about sharing your personal information with your counselor. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required
- Insurance providers and other third-party payer are given information that they request regarding services to clients

A court may not consider information that you also share, outside if counseling, willingly and publicly, protected or confidential. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with you counselor. You may also contact: www.dshs.state.tx.us/counselor/default.shtm.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date:

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Release of Information & Consent Form

Client Name: _____ Date of Birth: _____

Address _____ Phone: _____

I, _____ , hereby authorize the release and

exchange of information specified below between:

_____

Name/Title or Organization Name (i.e., Psychiatrist, Primary Care Physician, or entity

_____

Organization Address

_____

Phone/Fax

And:

Tim E. Gusey, LPC
105 N. Gordon St. Suite 202
Alvin, Texas 77511
P: 281-585-0000 F: 281-585-0080

This release of information shall be limited to the following specific types of information:

___ Assessment	___ Nursing/Medical Information	___ Demographic Information
___ Diagnosis	___ Toxicological Reports/Drug Screens	___ Current Treatment Update
___ Psychosocial Evaluation	___ Discharge/Transfer Summary	___ Progress in Treatment/Notes
___ Psychological Evaluation	___ Medication Management Info.	___ Continuing Care Plan
___ Treatment Plan or Summary	___ Presence/Participation in Treatment	___ Educational Information
___ Other _____	___ Other _____	

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services. If other purposes, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Tim E. Gusey, LPC. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the client or someone authorized to act on his/her behalf. I undetstand that this authorization authorizes the release of all medical records including psychiatric, Alcohol, and Drug Abuse.

_____

Client Name (Printed)

_____

Client Signature Date