PROMASSAGE
INTEGRATIVE HEALTH SOLUTIONS

Counseling Intake Form

Please provide the following information and answer the questions below.
Please note: all information you provide here is protected as confidential information.

Name: Last_____ First_____ MI_____

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

Last_____ First_____ MI_____

DOB:_____ Age:_____ Gender:_____

Address: _____

City: _____ State: ___ Zip:_____

Home phone: _____ Cell/other phone: _____
May we leave a message? ___ Yes ___ No

Email address: _____
May we email you? ___ Yes ___ No
**Note: Email correspondence is not considered to be a confidential medium of communication.*

Marital Status:
___ Never married
___ Domestic Partnership
___ Married
___ Separated
___ Divorced
___ Widowed

Please list any children/age:
_____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____

Referred by:_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ___ Yes ___ No

Are you currently taking any prescription medication? ___ Yes ___ No
If yes, please list below:

Medication:	Date started:	Date stopped:

Have you ever been prescribed psychiatric medication? ___ Yes ___ No
If yes, please list below:

Medication:	Date started:	Date stopped:

General Health and Mental Health Information:

1. How would you rate your current physical health?
   ___ 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?
   ___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very good
   Please list any specific sleep problems you are currently experiencing:

   _____

   _____

   _____

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

   What type of exercise do 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?
   __ Yes __ No
   If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   __ Yes __ No
   If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? __ Yes __ No
   If yes, please describe: _____

   _____

   _____

   _____

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

9. Do you engage in recreational drug use? __ Yes __ No
   If yes, please list drug(s): _____
   How often: __ Daily __Weekly __ Monthly

10. Are you currently in a romantic relationship? __ Yes __ No
    If yes, for how long? _____
    On a scale from 1-10, 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 (father, grandmother, sibling, uncle, etc.)

		Family Member:
Alcohol/Substance	___ Yes ___ No	_____
Abuse - Mental	___ Yes ___ No	_____
Abuse - Physical	___ Yes ___ No	_____
Abuse - Sexual	___ Yes ___ No	_____
Anxiety	___ Yes ___ No	_____
Bipolar Disorder	___ Yes ___ No	_____
Depression	___ Yes ___ No	_____
Domestic Violence	___ Yes ___ No	_____
Eating Disorders	___ Yes ___ No	_____
Obesity	___ Yes ___ No	_____
Obsessive Compulsive	___ Yes ___ No	_____
Schizophrenia	___ Yes ___ No	_____
Suicide Attempts	___ Yes ___ No	_____

Additional Information:

1. Are you currently employed? ___ Yes ___ No
   If yes, what type of work do you do? _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____

2. Do you consider yourself to be spiritual or religious? ___ Yes ___ No
   If yes, please 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?
   _____
   _____

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Disclosure Forms
Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal 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. Noted exceptions are as follows:

Duty to Warn and Protect
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. 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.

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.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies (when applicable) and third-party payers are given information that they request regarding services to clients.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description or impairment, progress of therapy, case notes, and summaries.

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

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

_____
Today's Date

Disclosure Forms
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 session fee is charged for missed appointments or cancellations with less than 24 hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show or cancel an appointment.

Thank you for your consideration regarding this important matter.

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

_____
Today's Date

Authorization for Use or Disclosure of
Protected Health Information

1. Client's name: _____
   First Name Middle Name Last Name
2. Date of Birth: __/__/__
3. Date authorization initiated: __/__/__
4. Authorization initiated by: _____
   Name (client, provider, or other)
5. Information to be released:
   Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it and authorization for any other type of protected health information)
6. Purpose of Disclosure: The reason I am authorizing release is: My request

   Other (describe): _____
7. Person(s) authorized to make the disclosure:

   _____
8. Person(s) authorized to receive this disclosure:

   _____
9. This authorization will expire on __/__/__ or upon the happening of the following:

   _____

Authorization and Signature:
I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____
Signature of the Patient

_____
Signature of Personal Representative Relationship to Patient

_____
Date of Signature

Patient Rights and HIPAA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time.

1. Tell your mental health professional if you do not understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional, and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat your or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. **Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.**
   HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as therapist, psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization must be separate from an authorization to release other medical records.