



Start Fresh Counseling Center, Inc

Client Intake form

Please complete this form to the best of your knowledge prior to starting services with Start Fresh. This will help ensure that all contact information is accurate and up to date.

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

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

If 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: _____



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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, for approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias?

No Yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No 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?



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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 (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? _____



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Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

- Duty to Warn and Protect- If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.
- Abuse of Children and Vulnerable Adults- If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.
- Prenatal Exposure to Controlled Substances- Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.
- Minors/Guardianship- Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.
- Insurance Providers- Insurance companies and other third-party payers are given information that they request regarding services to the clients. The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.



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By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

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

Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

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

Date



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Authorization for Use or Disclosure of Protected Health Information

Client Information

Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Email Address: _____

Address: _____

Home Phone: _____ Cell/Work Phone: _____

Recipient Information

I, _____, do hereby authorize _____
to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____ Address: _____

Date of Authorization: ___/___/_____

Authorization to expire on ___/___/_____ or upon the happening of the following
event: _____

Information to be Released

(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

My entire mental health record

Only those portions pertaining to: _____

(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for
Psychotherapy Notes, you must not use it as an authorization for any other type of
protected health information.)

Other: _____



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Purpose of Information Release:

- Further mental health care Payment of insurance claim Legal investigation
 Applying for insurance Vocational rehab, evaluation
 Disability determination At the request of the individual
 Other (specify): _____

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.

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

Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

- Patient is: minor incompetent disabled deceased
Legal authority: parent legal guardian representative of deceased