Thriving Mind Therapy

ADULT INTAKE FORM

Please answer all the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service.

I. GENERAL INFORMATION

Full Name:	Today's Date
Nickname:	Preferred Pronoun:
Age:	Date of Birth:
Ethnic/cultural background:	Primary Language:
Address:	
Contact Phone:	Contact Email:

In case of an emergency, who may I contact on your behalf?

Name:	Relationship:
Phone Number:	

II. REFERRAL INFORMATION

Briefly describe your reason(s) for seeking help at this time:
Do you have supportive people in your life? Yes/No If so, who?
Who referred you?

III. FAMILY RELATIONSHIPS (Please identify the people living in your home below)

Name	Sex	Age	Relationship to You (i.e., person is my son, partner etc.)	Please list any concerns or conflicts you have with this person

Are you currently in a custody dispute? Yes/No

Children: (List other children, including biological, adopted, foster, and stepchildren not living at home)

Name	Sex	Age	Relationship to You (i.e., person is my son)	Please list any concerns or conflicts you have with this person

How would you describe your relationship with your children?
How do you and the child(ren)'s other parent(s) get along?
What would you say your strengths as a parent are (what do you do well)?
Weaknesses or areas you would like to improve?

If you have previously been married, please fill out the following section:

	Date began:	Date ended:	Ex Spouse name	Children
1st Marriage				Yes/No
2nd Marriage				Yes/No
3rd Marriage				Yes/No

Family of Origin

Your Mother's Name:		Your Father's Name:	
Her Date of Birth/Age:		His Date of Birth/Age:	
Where does she live:		Where does he live:	
Describe your relationship with her:		Describe your relationship with him:	

Did your mom have any complications during conception, gestation, or delivery of you?

Who in your family suffers from alcoholism, addiction, an eating disorder, anxiety, depression, or anything that might be considered mental illness (diagnosed or undiagnosed)?

Significant Others-Please identify people NOT in your home that are significant in your life:

Name	Sex	Age	Relationship to You (i.e., person is my mom, sister)	Please list any concerns or conflicts you have with this person

Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating
Current partner's name:	Partner's Occupation:	Length of Relationship:	
How satisfied are you with your current relationship (on a scale from 1-10)? (Very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (Very satisfied)			

IV. EDUCATIONAL HISTORY

Highest level of education:	High school	Some college	College degree	Graduate School	Other
Did you fail any grades? Yes/No If yes, which ones?					
What grade(s) did you get most often? (Please Circle One) A B C D F					
Were you ever suspended or expelled from school? Yes/No					
Were you involved in extracurricular activities? Yes/No If yes, what?					
If you received a college/graduate degree, what was your degree in?					
If you are currently a student, what are you studying?					
Did you have any learning difficulties? Yes/No If yes, please explain					
What is your occupation?			Employer:		
Do you enjoy your occupation: Yes/No			Average hours worked per/week:		

V. SOCIAL HISTORY

How many friends did you have in your childhood? (Please circle one) Many Few None
How many friends do you have currently? (Please circle one) Many Few None
What social groups or activities are you currently involved in?
Religious affiliation as a child: As an adult:

How would you describe your spiritual or religious beliefs?
Do you attend religious services? (Please circle one) Regularly Once in a while Never

VI. MEDICAL HISTORY

Do you have a primary care physician? Yes/No	Physicians name:
Are you under the care of a psychiatrist? Yes/No	Psychiatrists name:

Are you under the care of a medical specialist? Yes/No

If yes, please circle type of specialist:

Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with (including when you were a child):

Illness/Disability	Dates

Please list any significant experiences you have had with high fever, head trauma, loss of consciousness, or surgery.

Significant Experience	Dates

List all medications you are currently taking:

Medication	Dosage	What it is treating

Are you taking the medications according to your doctor's recommendation? Yes/No
If no, briefly explain:

Average number of hours you sleep at night?	How long does it take for you to fall asleep? min. hrs.

Do you wake up in the night? Yes/No	If yes, how often? times per night.
How would you rate your overall sleep at the present time? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
Do you exercise on a regular basis? Yes/No If yes how often? times per week.	
If yes, please briefly describe activity:	
How would you rank your overall diet on a scale from 1-10? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
How would your rank your overall health on a scale from 1-10? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
How do you cope with stress?	What things are you currently doing for self-care?
What are your strengths?	How would you describe your self-esteem?

VII. SUBSTANCE ABUSE HISTORY

Have you EVER used any of the following legal or illegal drugs?

Substances	Yes/No	How old were you when you first used the substance?	Are you currently using this substance?	How often do you use this substance?	On average, how much do you use each time?
Cigarettes					
Alcohol					
Marijuana					
Cocaine					
Meth.					
Other					

Have any of the above drugs ever been a problem for you?	Yes	No
If yes, please describe:		
Have you ever tried to quit any of the above?	Yes	No
If yes, please describe:		
Have you ever participated in drug or alcohol rehabilitation program?	Yes	No
If yes, please describe:		
Do you have any other addictive behavior that is concerning to you or your family?	Yes	No
If yes, please describe:		
Does anyone in your family have a drug or alcohol problem?	Yes	No
If yes, please describe:		

VIII. PSYCHOLOGICAL HISTORY

Please share as much as you are comfortable disclosing at this time.

Have you ever received or given abuse? Yes/No	If yes, please circle type: Physical Emotional Sexual Neglect Other
If yes, describe briefly and age you were:	
Have you ever purposely hurt your body or attempted/seriously contemplated suicide? Yes/No	
If yes, describe briefly and indicate dates:	
Have you ever had any problems or concerns with eating? Yes/No	
If yes, please describe:	
Have you ever had a psychiatric hospitalization? Yes/No	
Have you ever seen a counselor/therapist before? Yes/No	
If yes, please fill out the following on your previous counseling experience(s):	

Therapist	Location	Dates	Reason for therapy

Do you feel it would be helpful for me to speak with your previous mental health care provider? Yes/No
Please describe how you have been feeling most days for the past two weeks?

IX. SEXUAL HISTORY

Do you consider yourself: Heterosexual Homosexual Bisexual
How did you learn about sex? Friends School Parents Other:
Compared to kids your age, did you enter puberty: Early On time Late
How old were you when you first became sexually active?
Have you had any sexual problems in the past? Yes/No
Are you having any now? Yes/No

X. Legal History

As an adolescent, did you have any trouble with the law? Yes/No If yes, please describe:
Have you ever been arrested? Yes/No If yes, please describe:

Have you ever been to jail or prison? Yes/No If yes, please describe:
Are you currently on any kind of probation or parole? Yes/No If yes, please describe:

I. MAJOR LIFE EVENTS

Have you experienced any of the following life events?

Event	Yes/No	If yes, please explain when and how you feel about the event:
Death of a loved one		
Divorce/Separation		
Car Accident		
Other accidents or injuries		
Surgeries/serious illness		
Moves (#___)		
Domestic Violence		
Miscarriage/Abortion		
Unemployment		
Legal problems		
Financial problems		
Disasters/Life threatening experiences		
Witnessed a horrific event		
What goals do you wish to accomplish during the therapy process?		

Thriving Mind Therapy

Client Agreement and Therapeutic Policies

Name: _____DOB: _____

Introduction:
This agreement is intended to provide you with important information regarding my professional services and business policies. This consent form will provide a clear framework for our work together and will facilitate our therapeutic relationship. Any questions or concerns regarding the content of this agreement should be discussed with me prior to signing it.

Unless you prefer otherwise, I will call you by your first name. Please call me Aubrey. I conduct all therapy sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture belief system exist between us, I will work to understand those differences.

Part I: Therapist Information

Educational/ Training Background:
I received my Master of Social Work from Walla Walla University in Walla Walla, Washington. I hold a Bachelor of Science in Social Work from Weber State University in Ogden, Utah. I am a Certified Trauma Specialist through Intensive Trauma Therapy in West Virginia. As well, I have additional specialized training in EMDR and Sandtray Therapy.

Professional Orientation:
I provide individual therapy for adolescents and adults. I also provide family therapy, group therapy, and parent consultations for clients in need of those services. The areas that I treat in my practice include but are not limited to trauma, anxiety, attachment, self-esteem, and stress in relationships.

I am a Licensed Therapist in the State of Texas. I am a professional member of the National Association of Social Workers.

I render therapeutic services in a professional manner consistent with accepted ethical standards as stipulated by Texas State Board of Social Worker Examiners and the HIPPA security and privacy rules. If at any time for any reason you have concerns or are dissatisfied with my services, please let me know. You may report any complaints.

Texas Department of Regulatory Agencies
The practice of licensed social workers is regulated by:
Texas State Board of Social Worker Examiners
Mail Code 1982 / P.O. Box 149347
Austin, Texas 78714-9347
Telephone: (512) 719-3521 or (800) 232-3162 and Fax: (512) 834-6677
E-mail: lsw@dshs.state.tx.us
Website: www.dshs.state.tx.us/socialwork

Part II: Client(s) Rights

You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you.

You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer.

You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. I ask you to please contact me by phone or in person before you make such a decision without prior discussion.

You have the right to expect that I will maintain professional and ethical boundaries by not entering in to other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

Client's Initial's_____

One of the most important rights involves confidentiality: within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or my professional standards.

Limits of Confidentiality:

1) Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

2) If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, I may warn the intended victim and notify the proper authorities.

3) If you, as a client, reveal a serious intent to harm yourself, I am ethically bound to do what I can to help maintain your safety, which may involve notifying others who may be of assistance.

4) If a judge orders my testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, I may be required to release your confidential information to the court.

In all the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities. Your confidentiality remains an *ethical priority*.

Client's Initial's_____

Legal action:

Please know that being a witness is not in my area of interest or expertise. If you are seeking therapy for court or court-related purposes, I will provide you with alternative referral sources. Should you, your attorney, your spouse, or ex-spouse's attorney, subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay $360 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to court-related process. You further agree to pay a retainer fee of $3,000 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me, it will be turned over to my attorney, and you will be billed for any attorney fees I incur on your behalf. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need a therapist testimony, please let me know before a therapeutic relationship is established, and appropriate referral sources will be provided to you. Please note: 24-hour advanced notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24-hour notification is not made, a fee of $2,880 will be billed. (8 hours @ $360/hr.)

Client's Initial's_____

Dual Relationships: I will avoid a therapeutic relationship with a friend, education or business associate and will avoid the development of a personal, education or business relationship with a therapy client. I do not

accept friend or contact requests from current or former clients on any social sites. Adding you as a friend could compromise confidentiality and privacy. If I see you in public, I will protect your confidentiality by greeting you only if you greet me first.

Client's Initial's_____

Part III: The Therapeutic Process

Benefits and Risks of Therapy: Psychotherapy is a process in which you and I discuss a variety of issues, events, and experiences for the purpose of creating positive change so you can experience your life more fully. Participating in therapy may result in several benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. There is no guarantee that therapy will yield any or all the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. This process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. The outcome of your treatment largely depends on your willingness to engage in the therapeutic process. Please address any concerns you have regarding your progress in therapy with me.

Client's Initial's_____

Emergencies: Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. If you need emergency help at a time when I am not available, please call 911, go to the nearest ER, or seek some other emergency service (such as 472-HELP, a 24-hour helpline).

Client's Initial's_____

E-Mail, Cell Phones, Computers and Faxes:
It is important to be aware that computers, E-mail, and cell phone communication can be easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails in general are vulnerable to such unauthorized access. *Please do not use e-mail for sensitive information or emergencies.*

Records and Administrative Services:
I may take notes during session and will also produce other notes and records regarding treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of my records, such a request must be made in writing. I reserve the right under Texas law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider.

Video or Audio:
You acknowledge and agree that neither you or I will record any part of your sessions unless you and I mutually agree in writing that the session may be recorded. You further acknowledge that I object to your recording any portion of your sessions without my written consent.

Client's Initial's_____

Professional Fees and Payments:

I am an out-of-network provider and do not verify insurance coverage, file insurance claims nor receive insurance payments. Upon request, a receipt with the necessary coding for you to self-file with your insurance company will be provided.

Your account must be paid IN FULL at the time of service unless a previous agreement has been made.

Acceptable forms of payment include cash, personal checks, Zelle, Venmo and PayPal. There is a $25 fee for returned checks.

If you are unable to keep your appointment it is your responsibility to notify Aubrey at (346) 704-1812 **at least 24 (business) hours prior** to the scheduled appointment. Failure to do so will result in a missed appointment charge, which is 50% of the session fee (1st time) and 100% of the session fee subsequent times. You will be required to pay in full prior to your next scheduled appointment. If you have collected a balance equal to two sessions, you are aware that you will not be able to schedule further sessions until all past-due fees are paid.

Client's Initial's_____

Fee Structure:

- $230 Initial intake and assessment (75-90 minutes)
- $155 Individual session (60 minutes)
- $180 Family session (75-90 minutes)
- $50 Per session for Group therapy (60-90 minutes)
- $1.00 Per page for Copying Record
- $360 Per hour for Legal Fees: phone time, letter writing, court appearances, travel

Paperwork or other requests will be a separate cost if not done during the allotted time.

You understand that if a phone session is ever needed outside of the regular scheduled session that there will be a $20 charge for the first 15 minutes and $20 for every 15 minutes following.

Payment is expected at the beginning of each session unless I have obtained permission to bill a clergy member on your behalf. Balances more than 120 days overdue may be subject to collection using a collection agency. However, I will first attempt to make other arrangements with you as needed. In general, it is important to discuss with me any issues that arise in connection with our financial arrangements, so that they do not hinder our working relationship.

Client's Initial's_____

I agree BY ENTERING therapy with Thriving Mind Therapy I will pay the full fee at each session. If I am late to a session, the length of the session may be shortened, and I agree to pay for a full session.

A 24-hour notice during business hours is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a missed appointment fee. I understand that this will be my responsibility, not that of a third-party payer.

I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, to ensure confidentiality.

Client's Initial's_____

CONSENT TO TREATMENT:

I, voluntarily, agree to receive and authorize Thriving Mind Therapy to provide such care, treatment, or services that are considered necessary and advisable for me and/or my minor child.

I have the legal authority to seek professional services for my minor child.

By my signature below, I acknowledge that I have read and understand this document, and any questions I had were answered.

I engage Thriving Mind Therapy to render services as provided herein.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____

Client signature (parent/guardian if minor) Date

_____

Child's Name Date

*I have provided Thriving Mind Therapy the latest custody order and/or divorce decree

_____

Parent Signature Date

_____

Therapist Signature Date

Thriving Mind Therapy

HIPAA NOTICE OF PRIVACY

Client Name: _____

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will receive response or be honored within 15 days.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

As a private practioner, I have the responsibility to:

1. Make each client aware of the Privacy Notice.
2. At any time make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated, you have the right to contact The U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/.

I have reviewed and understand this notice.

Client Signature: _____ Date: _____