EFP INTAKE PACKET

Name: _____

Date of Birth: _____ Age: ____ Gender: ____ Status: (Single, Student, Married, Divorced, Separated)
Circle one

Address: _____ City: _____ County: _____

Employed/ Occupation:

_____

Best number to reach you: _____ text or email: _____

Is it ok to leave you a message? Yes ____ No ____

Emergency Contact: _____ Relationship: _____

How did you find Divine Equine? Website, Friend, Physician, Referral, Other): _____

Information about Your Family:

I live with: Name Relationship to you Their Age

_____

_____

_____

( ) I Live Alone

Information about You:

What is your highest level of education? _____ Degree (Yes, No) yes, what is it in? _____
Vocational Certification? _____

Hobbies/Leisure: _____

Interest? _____

Military? (Y/N) ____ Years served? _____ DD214 (Y/N)_____Honorable Discharge (Y/N)____PTSD (Y/N)_____

Health Insurance Information:

Provider: _____ Policy Holder: _____
ID #: _____ Group#: _____ Relationship: _____

Your Relationships:

Marriage(s) or other significant relationships:

Name	Dates	Marriage/Divorce	Children (Y/N)

Your Health:

Do you have any medical concerns? (Y/N) _____ if so, please list: _____
_____
_____
_____

Have you ever had any other medical conditions or events that are/were significant in your life? _____
_____
_____

List all medications or drugs (legal or illegal) you take or have taken in the last year. _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Have you ever had a seizure? (Y/N) Do you have epilepsy? (Y/N) Have you ever fainted? (Y/N)

Have others in your household had concerns about your wellbeing? (Y/N) if so, list: _____
_____
_____
_____

Have you totaled ever your vehicle? (Y/N) if so, was it your fault? (Y/N) if so, what was the reason?
_____

Have you lost someone close to you? (Y/N) _____if so, Who and relationship to you:
_____ _____

Date of Last Tetanus Shot: _____

On this page is a list of words **please circle** all that have ever applied to your life (past/present).
Place a star beside your concerns and list reasons below.

Abuse-Emotional
Abuse-Neglect
Abuse-Physical
Abuse-Sexual
Addiction
Aggression
Anger
Anxiety
Attention Problems
Career Concerns
Childhood Issues
Child Custody
Co-Dependence
Commitment Issues
Compulsive Behavior
Concentration
Confusion
Crying
Cutting
Deaths
Decision Making
Depression
Divorce
Drug Use/Abuse
Eating Disorders
Emptiness
Failure
Fatigue
Fears
Financial Troubles
Friendship Problems
Goals not being met
Grieving
Guilt
Headaches
Health
Impulsive Spending
Impulsiveness
Indecision
Inferiority Feelings
Inhibitions
Internet Addictions
Interpersonal Conflicts
Irresponsibility
Irritability
Job/Employment Problems
Judgement Problems
Laziness
Legal Matters
Loneliness
Loss of Control
Low Energy
Low Frustration Tolerance
Low Income
Low Mood
Marital Problems
Marital Infidelity/Affairs
Medical Concerns
Memory Problems
Menopause
Mixed Feelings
Mood Swings
Motivation
Mourning
Obsessions
Outbursts
Overly Sensitive
Panic or Anxiety Attacks
Parenting
Perfectionism
Pessimism
Phobias
Poor Self-Care
Physical Problems
Pornography
Procrastination
Pregnancy
PTSD
Relationship Problems
Relaxation
Religious issues
Re-Marriage
Risk Taking
Sadness
School Problems
Self-Abuse/ Mutilation
Self-Centeredness
Self-Control
Self-Esteem
Self-Medicate
Self-Neglect
Separation (Spouse)
Separation (Children)
Sexual Conflicts
Sexual Dysfunctions
Sexual Harassment
Sexual (other issues)
Shyness
Sleeping Problems
Step-Parenting
Stress
Stress management
Suicidal Thoughts
Suicidal Attempts
Suspiciousness
Tenison
Thought Disorganization
Threats
Violence
Weight and diet issues
Withdrawal, Isolating

Please list all your Concerns: _____

_____

_____

RELEASE of INFORMATION:

I hereby permit Candace Ray, MA, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes, Such information may be released to HMO's and PPO's managed care organizations, IPA's Medicare/Medicaid, or other governmental or third part payors, or any organizations contracting with any of the above entities to perform such functions.

Signature: _____ Date: _____

Client, Parent, Guardian

You have the right to request that this office restrict uses and disclosures of your health information; this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Please see the Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on Candance Ray Website: www.shermancounseling.com and in the office. This Notice of Privacy Practices is also provided to you in your intake packet if you consent to revised in the future, you may obtain a revised copy from this office.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's Medicare/Medicaid, or other governmental or third part payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the client, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and ament your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human

Services. You may ask to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice