Intake Packet

Name: _____ Date: _____ Referred by: _____

Home: _____ Cell: _____

Address: _____ City: _____ Zip: _____

Age: _____ Birthdate: _____ Email: _____

Please list how long to all that apply below:

Married: _____ Partner: _____ Single: _____ Separated: _____ Divorced: _____ Widowed: _____

Ethnicity: _____ Religion: _____

Emergency contact: _____ Phone #: _____

Relationship to client: _____

Are you currently in other counseling? [ ] Yes [ ] No

If yes, name and address: _____

Prior counseling, name(s) & date(s): _____

_____

Current medications / dosages (including over the counter): _____

_____

Have you had any problems with medications? _____ If yes, details: _____

_____

Any difficulty with drugs or alcohol? (legal, relational, occupational or personal?) _____

_____

_____

Major reason for seeking help at this time? _____

_____

_____

How long have you had these problems or symptoms? _____

_____

_____

Why did you seek help now? _____

_____

_____

Intake Packet

Do you have any serious or chronic medical conditions? If yes, dates & details:

Do you have any chronic pain, recurring body aches, or soreness? Where is your body distress?

Have you had any serious accidents/head injuries/seizure activity? If yes, dates & details:

Do you have any recurring nightmares? (describe)

Who loved you unconditionally from 0 to 18 years of age? Who gave you positive reinforcement?

Who loves you and supports you in your life now?

What is your spirituality or source of peace, love or joy?

What spiritual resources do you have, if any? By what name do you call your spiritual supports?

What characteristics do you like most about yourself?

Do you have any performance goals you would like to meet?

What states of being do you desire to live in or return to? (peace, joy, creativity?)

Have you lost any parts of yourself you would really like to have back in your life?

Intake Packet

THE AMEN CLINIC QUESTIONNAIRE

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

____ 1. Frequent feelings of nervousness or anxiety

____ 2. Panic attacks

____ 3. Avoidance of places due to fear of having an anxiety attack

____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)

____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)

____ 6. Tendency to predict the worst

____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)

____ 8. Conflict avoidance

____ 9. Excessive fear of being judged or scrutinized by others

____ 10. Easily startled or tendency to freeze in intense situations

____ 11. Seemingly shy, timid, and easily embarrassed

____ 12. Bites fingernails or picks skin

____ *Total number of questions with a score of 3 or 4 for questions 1- 12 (GAD)*

____ 13. Persistent sad or empty mood

____ 14. Loss of interest or pleasure from activities that are normally fun

____ 15. Restlessness, irritability, or excessive crying

____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness

____ 17. Sleeping too much or too little, or early morning waking

____ 18. Appetite changes/ weight loss or weight gain through overeating

____ 19. Decreased energy, fatigue, feeling “slowed down”

____ 20. Thoughts of death or suicide, or suicide attempts

____ 21. Difficulty concentrating, remembering, making decisions

____ 22. Physical symptoms; headaches, chronic pain, digestive problems

____ 23. Persistent negativity or low self esteem

____ 24. Persistent feeling of dissatisfaction or boredom

____ *Total number of questions with a score of 3 or 4 for questions 13-24 (MDD)*

Intake Packet

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

____ 25. Excessive or senseless worrying

____ 26. Upset when things are out of place or don't go according to plan

____ 27. Tendency to be oppositional or argumentative

____ 28. Tendency to have repetitive negative or anxious thoughts

____ 29. Tendency toward compulsive behaviors

____ 30. Intense dislike of change

____ 31. Tendency to hold grudges

____ 32. Difficulty seeing options in situations

____ 33. Tendency to hold on to own opinion and not listen to others

____ 34. Needing to have things done a certain way or you become upset

____ 35. Others complain you worry too much

____ 36. Tendency to say no without first thinking about the question (OFA)

____ *Total number of questions with a score of 3 or 4 for questions 25-36*

____ 37. Periods of abnormally happy, depressed or anxious mood

____ 38. Periods of decreased need for sleep, energetic on much less sleep

____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)

____ 40. Periods of increased talking or pressured speech

____ 41. Periods of too many thoughts racing through your mind

____ 42. Periods of increased energy level

____ 43. Periods of poor judgment that leads to risk-taking behaviors

____ 44. Periods of inappropriate social behavior

____ 45. Periods of irritability or aggression

____ 46. Periods of delusional or psychotic thinking

____ *Total number of questions with a score of 3 or 4 for questions 37 – 46 (BD)*

Intake Packet

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

____ 47. Short fuse or periods of extreme irritability

____ 48. Periods of rage without being provoked

____ 49. Often misinterprets comments as negative when they are not

____ 50. Periods of spaciness or confusion

____ 51. Periods of panic or fear for no specific reason

____ 52. Visual or auditory changes (seeing shadows or hearing sounds)

____ 53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)

____ 54. Sensitivity or mild paranoia

____ 55. Headaches or abdominal pain or uncertain origin

____ 56. History of head injury or family history of violence/ explosiveness

____ 57. Dark thoughts, may be homicidal or suicidal

____ 58. Periods of forgetfulness or memory problems

____ *Total number of questions with a score of 3 or 4 for questions 47- 58 (TL)*

____ 59. Trouble staying focused

____ 60. Spaciness or feeling like you're in a fog

____ 61. Overwhelmed by tasks of daily living

____ 62. Feels tired, sluggish, or slow moving

____ 63. Procrastination, failure to finish things

____ 64. Chronic boredom

____ 65. Loses things

____ 66. Easily distracted

____ 67. Forgetful

____ 68. Poor planning skills

____ 69. Difficulty expressing feelings

____ 70. Difficulty expressing empathy for others

____ *Total number of questions with a score of 3 or 4 for questions 59-70 (AD)*

Intake Packet

Mood Disorder Questionnaire (MDQ)

Name:_____Date: _____

Check (✓) the answer that best applies to you. Answer each question as best you can.	**Yes**	**No**
1. Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family in trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*		
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made througha personal evaluation by your doctor.**

CREDIT CARD AGREEMENT

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the therapist at your initial session.

Payment information:

Card type (circle one): MC Visa Amex Other

Name as shown on card: _____

CC number: _____

3-digit security code on back of the card: _____

Billing zip code associated with the card: _____

Expiration date: _____

This card may be charged for (initial all that apply):

_____ Regular session fees (at your request, as a convenience to you)

_____ Fees for cancellation without 24 hours' notice (according to PTC Policy)

_____ Delinquent session fees (fees more than 30 days overdue)

Agreement:

"I _____ (print name) have read and understand the terms of providing my credit card to Sound Body and Mind, LLC. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

_____ (Signature) _____ (Date)

Intake Packet

INFORMED CONSENT AGREEMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness, and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell us immediately.

We will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Therapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

CONFIDENTIALITY:

As part of the counseling process, we are bound by ethical responsibilities to keep confidential the information shared during the sessions, and we will not release any information without your written permission. There are important **exceptions to the confidentiality** of the counseling relationship. We are required by law to reveal certain information under the following circumstances:

a) **Disclosure of serious intent to do harm to self or others**
b) **Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse**
c) **If a court of law orders the release of specific information**

APPOINTMENTS:

The length of a usual appointment is 60 minutes. Appointments are usually scheduled weekly and on a regular basis until you have accomplished most of your goals and other arrangements are made.

CANCELLATIONS AND MISSED APPOINTMENTS:

Cancellation of appointments must be made at least 24 hours in advance. A credit card number will be taken at the onset of your counseling. Late cancellations will be charged at the regular hourly fee to your credit card. If you have a true emergency your credit card will not be charged.

PAYMENT:

Payment is expected at each session unless other arrangements have been made in advance. You are responsible for payment for all services rendered either by debit card, credit card, check or cash. All checks and credit cards will be paid to Kimberly Penning.

CHECKS/OVERDUE ACCOUNTS:

There is a $25 service charge for all checks returned by the bank.

THERAPEUTIC TOUCH:

On occasion, and only with your permission, we will use therapeutic touch during trauma therapy sessions. The touch may involve you remaining sitting on your chair or couch and receiving a supportive hand to hold,

or the grounding touch of a hand on your shoulder, neck, or back. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual and only happens if you as the client want or need it.

TELEPHONE, TEXT, AND EMAIL POLICY:

Generally, we ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. We encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rates (In 15-minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE:

We are what is referred to as an "Out of Network Provider." We do not bill your insurance company and payment is due at each session, or first session if a package of sessions has been purchased.

PHYSICAL EXAMINATION:

We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

TRAINING AND SUPERVISION:

Your session will be provided by a pre-licensed therapists. Your case may be discussed in individual supervision format with a licensed supervisor present for feedback, education, and discussion.

EMERGENCIES:

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Mental Health Crisis Hotline (800-442-HOPE (4673) or online chat (http://hopeline.com)

If you have any questions about our policies or about services offered, please ask before signing below. Your signature indicates that you have read our policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate therapy if you do not comply with the policies or if we feel you are not benefiting from treatment.

Client signature: _____ Date: _____

Counselor signature: _____ Date: _____