Jodi G. Dunphy, M.A., LPC, LLC

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CONFIDENTIAL - ADULT COUNSELING INTAKE FORM

Name_____ Appointment Date_____

Age _____ Sex _____ Date of Birth _____/_____/_____

Mailing Address _____
Street City State Zip

Phone(h) _____ Phone(c) _____ Phone (w) _____

Email Address _____

For Confidentiality when and where do you prefer to be reached? _____

How did you hear about this counseling office? _____

Current Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

Spouse's Name: _____

Number of Children and ages: _____

_____

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Emergency Contact: Name: _____ Phone: _____

Relation to you: _____

REASONS FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

_____

Where are your concerns causing the most problems for you? Check all that apply: ___ Home ___ Work
___ Marriage ___ God
___ Other Relationships

When did your present concern begin to be a problem for you? _____

Please rate the severity of your present concerns on the following scale.
Check one: ___ Mild ___Moderate ___ Severe

What do you hope to gain from counseling _____

MEDICAL/HEALTH INFORMATION

☐ Good ☐ Fair ☐ Poor Date of last physical exam:_____

Do you have a physician, if so provide the name: _____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems):

☐Yes ☐No If yes, please explain: _____

Medications (Over-the-Counter or Prescription)	Dosage	Reason for Medication

Have you ever had surgery? If yes, for what reason? _____

Have you ever been hospitalized for mental illness or substance abuse? ☐ Yes ☐ No

If yes, for what specific reason?

_____

Have you ever participated in counseling before? ☐ Yes ☐ No

If so, when and why? _____

_____

OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation _____ Employer _____

If Currently a Student: Field of Study _____ ☐ Part-Time ☐ Full Time

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other:

_____

Military Service (including dates): _____

RELIGIOUS BACKGROUND

Religious Affiliation: _____ ☐ Active ☐ Inactive

How significant is your religion to your everyday life? _____

Please indicate which of the following areas are currently problems for you. Check all that apply:

- ❑ Under too much pressure/feeling stressed
- ❑ Excessive anxiety or worry
- ❑ Feeling lonely
- ❑ Angry feelings
- ❑ Concerns about finances
- ❑ Feeling "numb" or cut off from emotions
- ❑ Angry outbursts
- ❑ Excessive fear of specific places/objects
- ❑ Difficulty making friends
- ❑ Feeling as if you'd be better off dead
- ❑ Feeling that people are "out to get you"
- ❑ Feeling manipulated or controlled by others
- ❑ Difficulty making decisions
- ❑ Loss of interest in sexual relationship
- ❑ Feeling sexually attracted to members of your own sex
- ❑ Concerns about physical health
- ❑ Loss of appetite/increased appetite
- ❑ Lacking self confidence
- ❑ Recent significant weight gain/loss
- ❑ Use of alcohol
- ❑ Use of non prescription/prescription drugs
- ❑ Feeling distant from God
- ❑ Hallucinations
- ❑ Inability to concentrate while at school/work
- ❑ Crying spells
- ❑ Nightmares
- ❑ Loss of interest in usual activities/lack of motivation
- ❑ Obsessions or compulsions with specific activities or thoughts
- ❑ Inability to control thoughts
- ❑ Feeling trapped in rooms/buildings
- ❑ Hearing voices
- ❑ Blackouts or temporary loss of memory
- ❑ Sleeping too much or too little
- ❑ Feeling driven

Any other information that you feel is important to share that is not covered above:
(use the back of this page if needed)

_____

_____

_____

DISCLOSURE STATEMENT

In the interest of full disclosure about the counseling you will be receiving, please read through this following agreement (sign when requested), and sign/date at the bottom. This form must be signed and included with the intake form in order to begin counseling.

DESCRIPTION OF COUNSELING

My counseling philosophy is holistic in that three interrelated perspectives are explored in counseling: the Existential (the person), the Situational (his/her world), and the Normative (his/her God). Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. I adhere to the Code of Ethics prescribed by South Carolina Code of Ethics for Mental Health Professionals and the American Association of Christian Counselors. If you would like a copy of these codes, please ask for one.

REFERRAL POLICY/DISCLAIMER

Clients will be referred to another counselor when treatment required is beyond the scope of care available. Though I strive to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. I am not liable for any services provided or not provided by the referred professional. Once an intake evaluation has occurred, a chart will be opened as a new client. Any chart that has not been active in one year will be considered inactive and the chart will be closed and you will no longer be considered a current client.

FINANCIAL POLICY AND INFORMATION

Initial Evaluation fee is $160. The fee for a 50-minute session is $125. The fee for an 80-minute session is $160. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling. Cash, checks, and some credit cards are accepted forms of payment (there is a $30 charge on all returned checks.).
Jodi G. Dunphy, MA LPC LLC is not in network with any insurance providers. If you would like to file out of network, a form will be provided to you at the end of each session. Payment is due at time of service.

CONFIDENTIALITY

Generally speaking, information provided by and to a client in a professional relationship with a counselor is legally confidential. By law, information can only be released with the written consent of the client and only to parties specified by the client. There are specific exceptions to your right to confidentially which include: 1) Any suspected incident of child abuse or neglect; and 2) Imminent danger to self or others. When consulting with parents regarding minor children, specific content of therapy sessions with children or adolescents will be held in confidence unless their welfare requires that the parent(s) have access to such information. In most cases, joint meetings between children and/or adolescents, their parents and the therapist will be arranged as a part of the therapy process.

CANCELLATION POLICY

I request that you notify at least 24 hours before your scheduled appointment time if you need to cancel a session. Failure to do so will result in charges for the missed appointment. This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for sudden illnesses and emergencies only.

CONTACTING YOUR COUNSELOR

For scheduling and canceling your appointments, you must contact my office directly. For emergencies after hours, please contact 911 or go to your nearest emergency room.

If these guidelines are acceptable to you, please sign below:

_____ _____

Client/Guardian Signature Date

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