Client Intake + Consent Form

Client Name: ______________________________ Preferred Name?:_______________

Date of Birth: ____________ Age: ______ Parent/Guardian(if minor)__________

Gender Identity: Female – Male - Transgender Sexual Orientation:____________________

Street Address: ______________________ City/State: ____________ Zip Code: ________

Religious/Spiritual Affiliation (if any): ____

Cell Phone: ______________________________ Okay to leave a message? Yes - No

Email: ____

Note: Appt reminders are automatically sent at the time of booking.

In an emergency, whom do I call?

Emergency Contact Name: ___________________________________

Emergency Contact Phone: ___________________________________

Emergency Contact is my (relationship to you):_____________________

Does Emergency Contact Live with you? Yes - No

Any additional notes for the therapist?

____

____

____

- -

Welcome to Essence of Wellness Therapy!

I look forward to providing you with excellent and efficient counseling services. Please take your time to fill out this form. Remember, effective therapy is only made possible when the client is forthcoming about his/her own story, no matter how painful or uncomfortable those details may be. The information you provide will help me to better understand your world, as well as develop potential strategies in helping you to redesign your life.

R.R. Joseph, LMHC
Florida (Video Telehealth Sessions)

Essence of Wellness Therapy
E: contact@eowtherapy.com

eowtherapy.com
Ph: 239.888.9194

Social / Family Information

Which best describes you? Choose all that apply:

Never Married – Married – Separated – Divorced – Widowed – Engaged - Living Together - Same-Sex Partners – Just got out of a relationship/marriage

If you are currently in a romantic relationship, for how long? _____.

On a scale of 0 to 10 (with 10 being best), how would you rate your satisfaction with your current romantic relationship?_____.

On a scale of 0 to 10 (with 10 being best), how would you rate your satisfaction with your current relationship with SELF?_____.

Do you have children? If so, please provide names and ages: _____

If you have listed children, with whom do they live? _____

Do you have any pets in the home? If so, what type/names?_____

List any other individuals living in your home (other than you and any children/pets listed above):

_____

Medical and Mental Health History / Information

Are you currently being treated by a physician for any medical conditions? If so, please describe:

_____

Are you currently taking prescription, over-the-counter or herbal medication? No - Yes

Medication name/dose: _____

Have you ever seen a Psychiatrist or other mental health provider? No - Yes

If yes, which provider?_____ When? _____

What was the focus of treatment?_____

Was it helpful? Yes – No

How so?

_____

_____

Counseling Concerns

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

1. _____

2._____

3. _____

4._____

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/friends)?_____

What, if anything, has been helpful? _____

What are some of your coping strategies?

_____

_____

What do you consider to be your strengths?

_____

_____

Have you experienced any feelings of fear, terror, or helplessness in one, some, or all of the last 30-60 days? If so, please describe: _____

_____

_____

Counseling Goals

Goals are very important in counseling. They provide us with a focus and direction that will help me to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1. _____

2._____

3. _____

4._____

Risk Assessment

Is there any family history of mental illness or substance abuse? No – Yes

If so, please list their relationship to you & diagnosis:_____

Please list family, friends, support groups and community groups which are helpful to you:_____

History of Abuse? – Abuse explained:

Many times, when people hear "domestic violence" or "abuse," the thought of physical violence enters their mind. While this is certainly a type of abuse, it is not the only kind. Domestic violence (interchangeably known as "domestic abuse," "intimate partner violence," or "relationship violence") can include physical violence, sexual assault and molestation, emotional abuse and intimidation (including gaslighting), isolation, verbal abuse (coercion, threats, and blame), economic/financial abuse, reproductive coercion, digital abuse, and stalking. Contrary to popular belief, domestic violence is not caused by alcohol/substance use or anger. While these factors may certainly exacerbate the effects of the abuse, domestic abuse is about power and control. NOTE: This abuse is not always perpetrated by a family member in the home. It can be anyone who has/had access to you (school staff, neighbor, extended family member, friend, parent's bf/gf, coach, teammate, babysitter, etc). Together, we can explore the different kinds of abuse and the cycle of violence, create a safety plan (if necessary), and guide you on your journey to living a safe and peaceful life.

Please list any personal history of any form abuse, regardless of time or duration of occurrence(s):

_____
_____
_____
_____
_____
_____
_____

Has a family member or close friend ever committed suicide? No – Yes:(Who?)_____

Have you been having any thoughts of harming yourself or others? No - Yes: Self - Other(s)

If so, please state who and under what circumstances:_____

Are there any guns or weapons in your house? (specify whose & what type):

_____

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state who and under what circumstances:

_____

If you are currently employed, what do you do for work? _____

On a scale of 0 to 10 (with 10 being best), how would you rate your SATISFACTION with your current job/career?_____ STRESS LEVEL with your current job/career? _____

If you are currently IN SCHOOL, what is your area of study? _____

On a scale of 0 to 10 (with 10 being best), how would you rate your SATISFACTION with your current educational path?_____ STRESS LEVEL with your current educational path?_____

Alcohol / Substance Use Survey

How often do you have a drink containing alcohol?

Never 1/month or less 2-4/month 2-4/week more than 4/week

How many drinks containing alcohol do you consume on a typical day that you are drinking?

1 or 2; 3 or 4; 5 or 6; 7 to 9; 10 or more

Do you use marijuana or other "street drugs"? (Remember, this information is confidential) No - Yes what type/quantity/frequency of use: _____

[] I prefer not to answer in writing and choose to discuss this privately with the therapist.

Is there anything else that you would like the therapist to know?

_____

_____

Referral Source

How did you learn about this therapeutic practice?: Physician – Google - Online Ad (source):_____ Friend/Family:_____ Other _____

Client Consent

By signing my name below, I acknowledge that I have read, understand, and agree to the Disclosure Statements located at the bottom of eowtherapy.com/documents I acknowledge that I have read and understand this EOWT Intake+Consent, and I am requesting counseling services from R.R. Joseph, LMHC. I verify that I have provided the information on this form voluntarily and without any outside input. **I verify that the Driver's License/other Government-issued ID that I am providing for my e-file is valid.**
Signature:_____ Date:_____