Intake Form

The counseling we provide is unique to you, just as it is to all of our clients. To get started, we would like to gather some general information from you which will be kept confidential. Fill out, download or take a photo of both pages and return via email to kimmie.mhwgroup@gmail.com.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth | Social Security Number

Address

City | State | Zip Code

Main Phone | Alternate Phone

Email Address

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with our office in the case of an emergency?

☐ Yes ☐ No

Please List any medication you have taken or are taking:

Medication | Date | Side Effects/Benefits

_____

_____

Please Check all that apply:

☐ Depressed mood	☐ Excessive talking	☐ Unreasonable fear
☐ Lost or gained weight	☐ Racing thoughts	☐ Fear of social situations
☐ Not enough sleep	☐Easily distracted	☐ Repetitive thoughts/behavior
☐ Too much sleep	☐ Over working yourself	☐ Upsetting memories
☐ Sluggish	☐ Impulsive behavior	☐ Recent loss/grief
☐ Agitated	☐ See/hear things not real	☐ Work/school problems
☐ Never tired	☐ Suspect things may not be real	☐ Violent thoughts/behaviors
☐ Cannot concentrate	☐ Tense/unable to relax	☐ Self harm
☐ Afraid to leave home	☐ Excessive worry	☐ Anger outburst
☐ Inflated self-esteem	☐ Panic attacks	☐ Careless, high-risk behavior
☐ Feel guilty or worthless	☐ Thoughts of death or suicide	☐ Financial problems

Consent to Short-Term, Psychological Triage Services

You, or your minor, are about to take an especially important step towards a mental heath and wellness plan. Mental Health & Wellness Group acts as First Responders to any psychological trauma. You are our client and have confidentiality rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of harming themselves or has made threats to hurt someone else. If we feel it is in your best interest to communicate with an outside source, we will make referrals accordingly with your approval. To assure excellent counseling care and follow-up, you agree that attending all weekly appointments are required until the 30-day Triage Services have been completed. **_____ (Initial)**

I understand that Mental Health & Wellness Group will provide short-term psychological first aid in an emergency situation for traumatic public health settings such as Pandemic pressures, the workplace, the military, faith-based organizations, mass disaster venues, and even the demands of more commonplace critical events, e.g., dealing with the psychological aftermath of accidents, robberies, suicide, homicide, or community violence. **_____ (Initial)**

I understand that no promises have been made to me as to the results of this short-term care. I also understand that Mental Health & Wellness Group share no affiliations with groups or organizations referred and share no profit or compensation from those referred. **_____ (Initial)**

I understand that Mental Health & Wellness Group will neither assume nor offer any medical or mental health diagnosis. The goal of Mental Health & Wellness Group is to facilitate an immediate evaluation of my psychological health, my wellbeing, and my safety during any current or potential crisis with the sole purpose of alleviating any anxiety, stress, depression, and/or grief in a short-term counseling and coaching environment. **_____ (Initial)**

Client Name (Please Print):_____

Client Signature _____ Date: _____