FLORIDA COUNSELING FOUNDATION COUNSELING SERVICES

Roger Shepherd and Associates

CONFIDENTIAL INTAKE FORM

GENERAL INFORMATION

Full name: _____ Date: _____

Ethnicity: ❑ Asian ❑ Biracial/bicultural ❑ Black/African American ❑ Caucasian ❑ Hispanic/Latino ❑ Other

Sex: ❑ Male ❑ Female Date of birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell phone _____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No
Text Message OK? ❑ Yes ❑ No

Home Phone_____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Work phone _____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Email:_____ Contact you here? ❑ Yes ❑ No

Employer:_____ How long have you been there:_____

Occupation: _____ Average hours worked per week: _____

Highest level of education completed: _____ Are you currently in school? ❑ Yes ❑ No

If yes, what level?_____ Degree pursuing: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

How did you hear about us?

❑ Website ❑ Friend ❑ Relative ❑ Pastor ❑ Referred by another counselor

❑ From Christian Sharing Center (If you check this box you are giving The Christian Sharing Center permission to know that you are receiving counseling from Florida Counseling Foundation—and you understand that special arrangements have been made for payment for your sessions)

RELATIONAL INFORMATION

Relationship status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced
❑ Widowed ❑ Cohabitating and unmarried ❑ Partnered ❑ Unsure

How long have you been that status? _____

Number of previous marriages for you?_____For your partner/spouse? _____

Spouse's name: _____ Spouse's age: _____

Is your spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ Spouse doesn't know

With whom do you currently live? (*Check all that apply*) ❑ Alone ❑ Spouse ❑ Children ❑ Parent(s) ❑ Sibling(s)
❑ Boyfriend ❑ Girlfriend ❑ Roommate ❑ Other: _____

List your children (including step, adopted, foster, deceased) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _____

Have you ever had a ❑ miscarriage or ❑ medical abortion? ❑ Yes ❑ No. If Yes, when _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

_____

_____

_____

Your height: _____ your weight: _____

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _____lbs. ❑ down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed:
(Use back if necessary)

Doctor & Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how:_____

Have any of your ❑ friends or ❑ family ever committed or attempted suicide? ❑ Yes ❑ No
If yes, when and who: _____

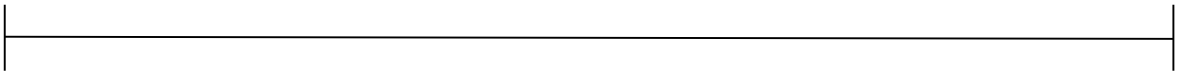
Are you presently experiencing any thoughts of harming yourself or another person? ❑ Yes ❑ No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Past/Present	Past/Present	Past/Present
❑ ❑ Stress	❑ ❑ Fears	❑ ❑ Controlled by others
❑ ❑ Anxiety or worry	❑ ❑ Shyness	❑ ❑ Obsessive thoughts
❑ ❑ Panic	❑ ❑ Low self-esteem	❑ ❑ Compulsive behaviors
❑ ❑ Depression	❑ ❑ Don't like myself	❑ ❑ Seeing things others don't see
❑ ❑ Crying all the time	❑ ❑ Marital problems	❑ ❑ Hearing voices
❑ ❑ Lack of motivation	❑ ❑ Other relational problems	❑ ❑ Racing thoughts
❑ ❑ Fatigue/Lack of energy	❑ ❑ Parenting problems	❑ ❑ Eating problems
❑ ❑ Poor appetite or overeating	❑ ❑ Physical abuse	❑ ❑ Drug use
❑ ❑ Trouble sleeping	❑ ❑ Emotional abuse	❑ ❑ Alcohol use
❑ ❑ Poor concentration	❑ ❑ Verbal abuse	❑ ❑ Pregnancy
❑ ❑ Feeling worthless or inferior	❑ ❑ Sexual abuse	❑ ❑ Abortion
❑ ❑ Feeling hopeless	❑ ❑ Sexual problems	❑ ❑ Legal matters
❑ ❑ Guilt	❑ ❑ Gender identity	❑ ❑ Work stress
❑ ❑ Death of friend or loved one	❑ ❑ Anger	❑ ❑ Career choices
❑ ❑ Grief	❑ ❑ Aggressive behavior	❑ ❑ Indecisiveness
❑ ❑ Chronic pain	❑ ❑ Bad dreams	❑ ❑ Lack of discipline
❑ ❑ Physical disability	❑ ❑ Unwanted memories	❑ ❑ Financial problems
❑ ❑ Terminal illness	❑ ❑ Loss of control	❑ ❑ Spiritual apathy
❑ ❑ Health concerns	❑ ❑ Impulsive behavior	❑ ❑ Other_____
❑ ❑ Loneliness	❑ ❑ Controlling	❑ ❑

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.



Minimally Distressing | Moderately Distressing | Extremely Distressing

Please describe why you are coming to counseling *(i.e., what are your issues, problems?)*:

_____
_____
_____

Why have you decided to come for counseling now?

_____
_____
_____

What do you hope to gain or change by coming for counseling?

_____
_____
_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____

FLORIDA COUNSELING FOUNDATION

Roger Shepherd, Director

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*.

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your Protected Health Information to family members and relatives, friends, or others you identify. We reserve the right to deny this request.

- You may request an amendment to your Protected Health Information.

- You may request alternative means or locations in which you receive confidential communications.

- You may request an accounting of disclosures of Protected Health Information beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your Protected Health Information and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- **The Privacy Officer**
  Skye Engel
  Florida Counseling Foundation
  258 Wilshire Blvd.
  Casselberry, Fl. 32707
  407-831-2991

For more information about HIPAA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  877 – 696 – 6775 (Toll free)

FLORIDA COUNSELING FOUNDATION
Roger Shepherd, Director

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____ have received a copy of Florida Counseling Foundation's Notice of Privacy Practices.

Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Signature of Client: _____ Date:_____
(Guardian if a minor)

Signature of Client: _____ Date:_____

Witnessed by:_____ Date:_____

Signature of Witness:_____

258 Wilshire Boulevard • Casselberry, Florida 32707 • 407-831-2991
floridashepherd@cs.com

Florida Counseling Foundation

258 Wilshire Blvd, Casselberry, FL 32707

Welcome to the counseling services of Steve Graham. I have working on obtaining a Master's Degree in Counseling Psychology from Hope International University. I am currently counseling under the supervision of Dan Miller, who is licensed in the State of Florida. This information sheet describes the process of psychotherapy and my office policies.

Outpatient psychotherapy may include diagnostic services, crisis intervention, individual, group, marital, or family therapy. Psychotherapy consists of face-to-face contacts between the person(s) involved in therapy and their therapist. The emphasis is on assisting the client in understanding his or her relational difficulties and expressing the feelings associated with these issues; assessing possible causes of the problems and previous attempts to cope with them; and exploring possible alternative courses of action and their consequences. Our goal is for you to benefit from therapy, but there are no guarantees that this will occur. At times, you may feel conflicted about your therapy as the process can be uncomfortable. Maximum benefits, however, can occur with regular attendance and diligent work.

- **Psychotherapy Sessions:** Each psychotherapy session is 50 minutes long. Your therapy session will begin and end at the designated times. On occasion it may happen that your session begins a few minutes late, in which case your session will end 50 minutes after it begins. However, if you are late, the session will end at the regularly specified time. The fee for each psychotherapy is $_____. Other fee schedules may be arranged with the therapist on an individual basis, depending on need and availability of discounted time slots.

- **Phone Time:** Between sessions you may need to talk with your therapist. I will be available to you by phone for a brief conversation of 5 minutes without charge and can be reached via my voicemail by calling (407) 276-7223. I will endeavor to return all phone calls within 24 hours. If the particular problem or situation requires more time, you can schedule time to meet before your next regular session or continue the telephone consultation at the same fee charged for a psychotherapy session, pro-rated to the nearest half-hour.

- **Canceled appointments: Appointments will be charged in full, unless a 24-hour cancellation notice is given.** When appointments are canceled in advance, rescheduling during the same week is advisable to ensure continuity of treatment. Planned absences such as vacations should be discussed early to prepare for the interruption. If for any reason you wish to discontinue treatment before a planned termination, please let your therapist know. Allow 2 appointments for closure/transiting out of treatment.

- **Payment:** Payment is due at the end of each session.

- **Video Recording Counseling Sessions for Training Purposes:** Video recording the sessions are a significant component of counselor training. However, no recording is ever done unless the client has given permission to do so. This consent form is utilized to obtain permission to video record, for educational training purposes only.

  Your signature below indicates that you _____(name of client or parent/ guardian of client) give _____(name of your counselor-in-training) permission to be audio/video record (circle one or both) and that you understand the following:

  1. I can request that the recorder be turned off at any time and may request that the recording or any portion thereof be erased. I may terminate this permission to record at any time.
  2. The purpose of recording is for use in training and supervision. This will allow the above referenced counselor-in-training to consult with his or her assigned supervisor(s) and practicum instructor in an individual or group supervision format, who may view the recording alone or in the presence of other counselors-in-training involved in direct supervision or practicum course.
  3. The contents of these recorded sessions are confidential and the information will not be shared outside the context of individual and group supervision or practicum course.
  4. The recordings will be stored in a secure location and will not be used for any other purpose.
  5. The recordings will be erased after they have served their purpose.

- **Confidentiality:** Information shared, **including that of minors,** is kept strictly confidential except when the following limitations apply:

  1. When the client communicates threat of bodily injury to another or is suicidal.
  2. When there is reasonable suspicion that child abuse or abuse to a dependent adult has occurred or will occur.
  3. When information is required by law or ordered by the court.
  4. When I receive regular professional consultations in which neither your name nor any identifying information about you is revealed without your expressed written consent.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Signed _____ Date _____