Adult Clinical Intake Form

Resilience Counseling - Private Practice, Amy Muse, MS, LPC

Personal Information:

Today's Date _____

Name: _____ Age: _____ Date of Birth: _____

Social Security Number: _____

Driver's License or State ID number and state issued: _____

Are you able to self-pay? ☐ Yes ☐ No
Who is your Health Insurance Provider: _____

Ethnicity _____ City/State/Country of Birth _____

Gender: ☐ Male ☐ Female ☐ Intersex ☐ Transgender (F to M) ☐ Transgender (M to F)

Current home address where you physically live:
_____
_____

Email: _____ May your counselor leave a message with you via email? ☐ Yes ☐ No

Personal Phone: (____)_____ May your counselor leave a message at your Phone Number? ☐ Yes ☐ No Is this a cell phone? ☐ Yes ☐ No

Work Number: (____)_____ May your counselor leave a message with at your Work Number? ☐ Yes ☐ No

What is your preferred contact method? ☐ Email ☐ Personal Phone ☐ Work Phone

Emergency Contact Person 1: Name _____
Relationship _____ Phone Number (____)_____
Email _____

Emergency Contact Person 2: Name _____
Relationship _____ Phone Number (____)_____
Email _____

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Who is your Primary Care Physician? (Clinic, Name and Phone Number) How long have you been a patient? (N/A if not applicable)

_____

_____

Who is your Psychiatrist? (Clinic, Name and Phone Number) How long have you been a patient? (N/A if not applicable)

_____

_____

Education Level: _____

Personal Interests or Hobbies:

_____

_____

Are you active in any community or social groups, if yes please describe?

_____

_____

Are you currently religious or spiritual? If yes please briefly describe your personal beliefs and/or affiliation.

_____

_____

What is your current relationship status?

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

How satisfied are you with your current relationship status?

Not Satisfied 1 2 3 4 5 Very Satisfied

Have you ever been convicted of a crime? If yes, please list the conviction(s) and when you were convicted? (Please include DWI or DUI if applicable)

_____

_____

Do you have any disabilities? If yes, please describe.

_____

_____

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What is your current employment status?

☐ Full-Time employed ☐ Part-Time employed ☐ Self employed ☐ Unemployed
☐ Retired ☐ Disabled from being employed ☐ Full-Time Student ☐ Part-Time Student

Are you satisfied with your current employment status?

Not Satisfied 1 2 3 4 5 Very Satisfied

If employed or a student, where are you employed and/or where do you attend school? (N/A if not applicable)

_____
_____

What is your current military status?

☐ No Military Service ☐ Active Duty ☐ Active Reserve ☐ Inactive Reserve
☐ Combat Veteran ☐ Veteran

Currently, what problems or concerns would you like to address?

☐ Personal Mental Health Concerns
☐ Family Concerns
☐ Intimate Relationship Concerns
☐ Financial Concerns
☐ Career/School Concerns
☐ Medical or Health Concerns
☐ Legal Concerns
☐ Parenting Concerns
☐ Addiction Concerns
☐ Abuse/Violence Concerns
☐ Grief/Loss/Death
☐ Other _____

How difficult has it been for you to deal with these concerns?

Not Difficult 1 2 3 4 5 Extremely Difficult

What counseling goals would you like to work towards with your counselor?

_____
_____
_____

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Childhood Relationship History:

Were you adopted? If yes, when? Was your adoptive parent(s)/guardian(s) a family member? If yes, please describe the relationship between your adoptive parent(s)/guardian(s) and your biological parent(s)?

_____
_____
_____

Who were you raised with?

_____
_____

Were your parents/guardians: single, married, divorced, and/or remarried?

_____
_____

What was the relationships like with your parents/guardians, siblings and/or other persons in the home?

_____
_____

What was your childhood like?
Not Difficult 1 2 3 4 5 Extremely Difficult

Who were the most influential persons for you during your childhood?

_____
_____
_____

Did you have any supportive persons for you in your childhood? If yes, who?

_____

Have you ever experienced any painful losses of relationships or breakups? (If yes, please describe what relationship(s) ended, how long each lasted and when each ended.)

_____
_____
_____

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Health, Stressor, and Trauma History:

Has anyone in your family had a mental illness, mood/behavioral problem or addiction problem? Please list who and what problems briefly, even if that person was never diagnosed or didn't receive any treatment or support that you were aware of.

_____
_____
_____

Have you ever received any type of counseling, mental health or psychiatric services? If yes, please list where, clinician/provider name, and when you received those services.

_____
_____
_____

Have you ever been hospitalized for mental health problems or behaviors? If yes, what facilities and when were you hospitalized?

_____
_____

If you have received mental health services in the past, what were your previous diagnoses or what issues were you working on?

_____
_____

Are you currently taking any medications for any medical or health conditions? If yes, please list all current medications and dosage.

_____
_____

Have you ever taken or are you currently taking any mental health medications? If yes, please list all of those medications including dosage and whether they are current or past.

_____
_____

Have you ever committed an act of violence or abuse on someone else? If yes, please describe: type of violence or abuse, who was hurt or abused and when it happened.

_____
_____
_____

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Have you ever harmed pets or animals outside of hunting? ☐ Yes ☐ No

Do you own or have easy access to firearms? ☐ Yes ☐ No

Have you ever experienced abuse, harassment, bullying or assault? If yes, when and by who?

_____

_____

Have you ever experienced sexual abuse, rape or sexual assault? If yes, when and by who?

_____

_____

Have you ever experienced a traumatic injury or been diagnosed with a life changing illness? If yes, please briefly describe the injury or illness and when this happened.

_____

_____

Have you ever witnessed or experienced a traumatic event, accident or incident that sticks with you or that you remember very vividly? If yes, please briefly describe.

_____

_____

Has anyone important to you died? Who, when and how did they die?

_____

_____

Has anyone in your friend or family circles ever killed themselves? If yes, please state the person's name and your relationship with the person?

_____

_____

Have you ever experienced thoughts of killing yourself or wishing you were dead? If yes, please state if this was in the past and when or if you are currently experiencing these thoughts?

_____

_____

Have you ever hurt yourself intentionally? (Examples: cutting yourself, burning yourself, hitting yourself, pulling out hair on your body, etc.) If yes, please describe.

_____

_____

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Have you ever told anyone that you were going to kill yourself or that you should kill yourself? ☐ Yes ☐ No

Have you ever attempted to kill yourself? If yes please state how and when.

_____

_____

Are you currently planning to kill yourself? ☐ Yes ☐ No

Have you ever experienced thoughts of killing anyone else? If yes, please list who it is or was that you want(ed) to kill and when you have had or if you are currently having these thoughts?

_____

_____

Are you currently planning to kill someone? If yes, who and when?

_____

_____

Have you ever experienced hallucinations or seen, heard, smelled or felt things that others could not see, hear, smell or feel? If yes please describe.

_____

_____

Have you ever behaved in ways that seem very abnormal for you and your usual style of life? If yes, please describe.

_____

_____

Do you ever find yourself going on spending sprees when you do not have the funds to cover such spending? ☐ Yes ☐ No

Have you ever gone periods of time where you needed little to no sleep and still felt energized without caffeine or stimulant use? If yes, please describe when this has happened to you.

_____

_____

Do you ever feel like ideas are racing through or around your mind at a very rapid speed?
☐ Yes ☐ No

Have you ever noticed that there are times that you uncontrollably speak in a pressured and rapid manner? Almost as if you can't get the words out fast enough? ☐ Yes ☐ No

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Do you find that your mood fluctuates quickly and strongly on a regular basis? ☐ Yes ☐ No

Have you noticed or has someone else ever commented that you may have an addiction problem? If yes, please describe the problem and/or substance(s) used.

_____

_____

Have you ever blacked out from taking pills, doing drugs or drinking alcohol? ☐ Yes ☐ No

How much caffeine would you say you consume, check all that apply? (coffee, hot tea, sweet tea, soda, energy drinks, etc.)

☐ None ☐ Daily ☐ Not every day but frequently ☐ 1-3 cups/day ☐ 4+ cups/day

Have you ever used or been prescribed any of the substances listed below? Please check all that apply to you.

☐ Nicotine
☐ Alcohol
☐ Marijuana
☐ Stimulants (Adderall, Cocaine, Meth, etc)
☐ Opiods (Hydrocodone, Oxycontin, etc.)
☐ Benzodiazapines (Xanax, Valium, etc)
☐ Hallucinogens (LSD, Mushrooms, MDMA)
☐ Other _____

Have you ever felt uncontrollably angry towards yourself or others; or do you feel angry almost all the time? ☐ Yes ☐ No

Do you often feel like you can't do anything right? ☐ Yes ☐ No

Do you feel uncomfortably isolated or alone? (Not including peaceful solitude) ☐ Yes ☐ No

Have you ever felt like you go through periods of time when you sleep too much and still don't feel rested? ☐ Yes ☐ No

Have you gained or lost more than 20 pounds without medical reason, your trying or without noticing in the past 3 month?

☐ Yes
☐ No
☐ My weight has always fluctuated
☐ Lost 20 pounds +
☐ Gained 20 pounds +

Have you ever felt very tearful or sad for no obvious reason? ☐ Yes ☐ No

When you feel sad or down, how long does this feeling last?

☐ Minutes
☐ Hours
☐ Days
☐ Months
☐ Years
☐ It seems like I've always felt this way

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Do you exercise excessively? ☐ Yes ☐ No ☐ Sometimes

Do you restrict your diet without medical or health professional advisement? ☐ Yes ☐ No

Do you binge and over eat to extremes? ☐ Yes ☐ No

Do you ever intentionally throw up after eating? ☐ Yes ☐ No ☐ Sometimes

Do you feel upset or stressed when plans or circumstances change or situations or persons behave in ways that are out of your control? ☐ Yes ☐ No

Do you often find yourself feeling stressed in social situations? ☐ Yes ☐ No

Do you find yourself feeling highly stressed in certain situations? If yes, please describe when this happens.

_____

_____

Do you ever feel like life pressures are too overwhelming and too much for you to handle?
☐ Yes ☐ No

Do you have any paralyzing fears or phobias that disrupt your life or relationships? If yes, please describe.

_____

How many hours do you typically sleep per day? _____

Do you have trouble sleeping? Please check all that apply to you over the last 6 months.
☐ Trouble falling asleep (takes more than 30min)
☐ Trouble staying asleep (wakes more than once per night)
☐ Nightmares
☐ I have to take something to get to sleep, What do you take? _____

Is there anything else that you can think of that is important for your counselor to know?

_____

_____

_____

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Informed Consent for Counseling, Confidentiality & Financial Disclosure:

Confidentiality:

- Your confidentiality is carefully guarded by your counselor and protected by Arkansas law under Privileged Information and professional ethical codes or practice as defined by the American Counseling Association (ACA) and the Arkansas Board of Examiners in Counseling. No information about your appointments or sessions will be released without your specific written authorization and consent. Confidentiality is legally limited. Those limitations include: if it becomes apparent in your counselor's professional opinion that you may do serious and foreseeable harm to yourself or to others, if information is subpoenaed by a court of law and in the case of mandatory reporting of child or vulnerable adult abuse/neglect.
- All counselor clinical notes compiled during the counseling relationship are for the counselor's professional use only. You are welcome to review your records at any time, as counseling is a collaborative process.
- As I am only accepting self pay clients, no third party billing parties or insurance companies will have access to your counseling records.

Client Rights:

- You are entitled to professional, compassionate and respectful counseling services. Your counselor will meet with you in a timely manner and for the agreed upon time frame.
- If your counselor needs to reschedule the counseling session, your counselor will make all efforts allowed by you to contact you for rescheduling at a time that works best for both of your schedules.
- If you are delayed or need to reschedule your session, please do so with as much notice as possible via email or phone call/message. If you are delayed, it may not be possible to give you the full scheduled time frame that day.
- Your initial appointment will be your intake interview and you and your counselor will go through your intake form to gather any important background information to be able to better address your concerns and goal setting. You and your counselor will determine what strategies are needed to best assist you in achieving your goals. Should your counselor determine that your concerns require resources or competencies beyond what your counselor can provide, you will be assisted with referrals and resources to appropriate sources.
- During the counseling process, you may encounter difficult memories or issues that you do not wish to discuss at that time. You are entitled to tell your counselor that you do not wish to discuss this information at this time and your counselor will respect your limits and boundaries.
- If for any you or your counselor decides to terminate the counseling relationship, you are entitled to a refund of any unused pre-paid counseling fees.

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Client Responsibilities:

- Your active, open and honest participation in the counseling process is essential for positive progress to be made. Change is not easy and can sometimes be uncomfortable, and counseling is for people who wish to make positive change in their lives. You will work with your counselor as a partner. This will require you to provide your counselor with feedback regarding the services and discuss what goals you would like to accomplish and integrate in between sessions.
- Payment for services is due the day of service or before. You will be charged any collection fees on missed payments and checks that are found to be insufficiently funded.
- If you miss an appointment without notifying your counselor via email/phone message in advance of your scheduled appointment, you will be charged for the scheduled time. (In cases of emergency, you must proactively communicate and provide adequate documentation to be exempt from being charged for the missed appointment.)

If you have any questions, please discuss them with your counselor.

I confirm that I have answered all questions on this form to the best of my ability. I consent to counseling with Amy Muse, MS, LPC and have read, understand and agree with the statements on pages 10-11.

_____	_____	_____
Your Printed Name	Your Signature	Date

_____	_____
Amy Muse, MS, LPC Signature	Date