Intake Form

1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

For confidentiality, when and where do you prefer to be reached?

_____

2. **Marital Status Please check and specify when applicable:**

☐ Single, never married
☐ Engaged for how long?
☐ Married for how long?
☐ Divorce in process for how long?
☐ Separated for how long?
☐ Divorced for how long?
☐ Live-in partner for how long?
☐ __ prior marriages (self)
☐ __ prior marriages (partner)

3. **Describe your current physical health:**

○ Good
○ Fair
○ Poor

4. **Please list any medications you are currently taking:**

	Medication	Dosage	Since when?	Adverse effects
1				
2				

5. **Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? List approximate dates:**

_____

6. **Type of counseling**

- ○ Individual
- ○ Family
- ○ Marital
- ○ Pre-marital
- ○ Couples
- ○ Career

7. Please describe what has led you to seek Counseling now?

How long has this been a problem for you?

Where do your current difficulties affect you?

○ Home ○ Family ○ Work ○ God ○ Marriage ○ Friends/Community

Has anyone else noticed?

Severity

8. **Have you dealt with any of the following emotional / behavioral problems? Check all that apply:**

- ☐ Alcohol abuse
- ☐ Drug use
- ☐ Impusivity
- ☐ Repeats words of others
- ☐ Concerns about finances
- ☐ Trouble sleeping
- ☐ Feeling lonely
- ☐ Hearing voices
- ☐ Concerns about body image
- ☐ Depressed mood
- ☐ Delusions
- ☐ Hopelessness
- ☐ Chronic lying
- ☐ Guilt
- ☐ Indecisiveness
- ☐ Self-injurious acts
- ☐ Under too much pressure/stress
- ☐ Inability to control thoughts
- ☐ Inability to concentrate on tasks
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Feeling trapped in rooms/buildings/cars
- ☐ Fatigue/Low energy
- ☐ Hallucinations
- ☐ Obsessions/Compulsions
- ☐ Distrustful
- ☐ Hostile/angry mood
- ☐ Not trustworthy
- ☐ Violent temper
- ☐ Feeling distant from God
- ☐ Feel like someone is watching me
- ☐ Loss of interest in usual activities
- ☐ Loss of sexual desire
- ☐ Feeling as if you'd be better off dead
- ☐ Increased anxiety/worry
- ☐ Panic attacks
- ☐ Phobias

If "other(s)", please specify

9. **Who suggested that you see a counselor?**

- ☐ No-one (self-referral)
- ☐ Friend
- ☐ Family member
- ☐ Partner
- ☐ Co-worker
- ☐ Other

If "other", please specify

10. What would you like to gain from counseling?

11. Have you ever seen a counselor before?
○ yes ○ no

If yes, when was that? Please list the mental health care providers (Counselor / Psychologist / Psychiatrist)' names and phone numbers:

12. What support do you have in your life (Family / Friends / School / Work / Social activities, etc)?

13. Please indicate how you would describe your childhood family experience:

- ○ Outstanding home environment
- ○ "Normal" home environment
- ○ Chaotic home environment
- ○ Witnessed physical/verbal/sexual abuse toward others
- ○ Experienced physical/verbal/sexual abuse from others
- ○ Other (please specify)

If "other", please specify

14. Do you have any difficulties with alcohol, drugs, cigarettes, addictions or food? If yes, please explain

15. Is there a history of alcohol/drug abuse in your family? Please use the box below to indicate the type of drugs and if the abuse is active or in remission:

- ☐ No-one
- ☐ Father
- ☐ Mother
- ☐ Sibling(s)
- ☐ Granparent(s)
- ☐ Stepparent (live-in)
- ☐ Uncle(s)/Aunts
- ☐ Spouse/Significant other
- ☐ Children
- ☐ Other(s)

If "other(s)", please specify

16. **Parents' current marital status. If a parent is no longer alive, please indicate the parent's marital status before passing:**

- ☐ Married to each other
- ☐ Separated for __ years
  _____
- ☐ Divorced for __ years
  _____
- ☐ Mother remarried __ times
  _____
- ☐ Father remarried __ times
  _____
- ☐ Mother involved with someone
  _____
- ☐ Father involved with someone
  _____

Additional info

_____

17. **What is your current living situation? Check all that apply:**

- ☐ Housing adequate
- ☐ Homeless
- ☐ Housing overcrowded
- ☐ Dependent on others for housing
- ☐ Housing dangerous/deteriorating
- ☐ Living companions dysfunctional
- ☐ Other

If "other", please specify

_____

18. **If currently employed:**

What is your occupation?

_____

Do you enjoy your work?

_____

How many hours a day do you work?

_____

Do you take work home with you?

_____

What is your current appx salary

_____

If currently a student - field of study

_____

Degree

_____

Institution

_____

Status

_____

How long have you been at current school or employer?

_____

19. **Religious Background**

Religious preference?

_____

Do you believe in God?

○ yes ○ no ○ not sure

How much does your religion impact your daily life?

_____

What church do you attend?

_____

Are you a member?

○ yes ○ no

_____	_____
Signature	Date

COUNSELING AGREEMENT

In order to be fully informed about the counseling you will be receiving, please read through the following Counseling Agreement. Your consent to the Counseling Agreement will be required at the first session.

Description of Counseling

Theron Huff Counseling approach to counseling is holistic in that we engage both the study of theology and psychology. Although our counselors are guided by a Christian worldview, your counselor will be sensitive to your religious/cultural differences and perspectives. Please refer to our website for more details on our approach. Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. Theron Huff Counseling adheres to the Code of Ethics prescribed by the American Counseling Association. To view our code of ethics, go to http://www.counseling.org/knowledge-center/ethics

Referral Policy/Disclaimer

Clients will be referred outside of Theron Huff Counseling when treatment required is beyond the scope of care available at Theron Huff Counseling. Though Theron Huff Counseling strives to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. Furthermore, Theron Huff Counseling is not liable for any services provided or not provided by the referred professional.

Counseling Fees

The fee for a 50-minute session is $125.00 unless otherwise stated. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling at Theron Huff Counseling. Cash or checks are accepted forms of payment (checks made payable to "Theron Huff Counseling")
*** **Please note that we are unable to accept insurance.** ***

Confidentiality

To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent. Please see the "**Notice of Policies and Practices to Protect the Privacy of Your Health Information"** given to you at your initial session for details. All counselors at Theron Huff Counseling participate in regular peer supervision. During this supervision your personal identity will be concealed. The purpose of supervision is to ensure quality of care received at Theron Huff Counseling.

Electronic Mail: Please be informed that electronic mail is not a guaranteed safe means to transmit confidential information. Due to the security risks and lack of immediacy, it is recommended that you do not communicate sensitive content via email and limit email contact. **Voicemail:** Please be informed that Theron Huff Counseling voicemail is not a guaranteed safe means to transmit confidential information. Due to the security risks and

lack of immediacy, it is recommended that you do not communicate sensitive content via voicemail and limit voicemail contact.

Rights as a Client

- You are entitled to information about any procedures, methods of counseling, techniques and possible duration of therapy.
- You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.
- You have the right to expect confidentiality within the limits described in the Notice of Policies and Practices to Protect the Privacy of Your Health Information.
- You have the right to request in writing the release of your records to any person or agency.
- You have the right to authorize your counselor to consult with another professional about your therapy in writing.
- You have the right to file a grievance in writing with the Director of Theron Huff Counseling if you have concerns that your rights as a client have been violated.

Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and client. The cost of such mediation, if any, shall be split equally.

Cancellation Policy

Theron Huff Counseling requests that you notify your Counselor at least **48 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.

In order to be fully informed about the counseling you will be receiving, please read through the following Counseling Agreement. Your consent to the Counseling Agreement will be required at the first session.

Contacting Your Counselor

For scheduling and canceling your appointments, you must contact your therapist directly by dialing their phone number or sending an email. Phone numbers and email address for all therapists can be found at counseling.theronhuff.com. For general information, please contact the Theron Huff Counseling main number during regular offices hours of 9:00 AM-5:00 PM at 267.457.4611. For emergencies after-hours, please contact 911 or your local emergency room.

Liability

It is my understanding that Therapy for Success, located at 123 S. Broad Street in Philadelphia, PA, is being used by Theron Huff Counseling as an office. Therefore, Therapy for Success is not liable/responsible for any services provided, or not provided, by the staff counselor at Theron Huff Counseling practicing at this office.

No Alcohol or Street Drugs

Please do not attend counseling sessions if you have taken alcohol or street drugs.

No Weapons

No weapons are allowed on the premises of Theron Huff Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

Voluntary Bed Bug Disclosure

Due to the resurgence of bed bug infestations in the United States and specifically Philadelphia, we are asking that all clients voluntarily disclose to us if they are experiencing bed bug activity ("activity"). Since bed bugs are skilled at hiding and typically come out at night, bed bug activity ("activity") shall be defined as any of the following:

- Actual sightings of bed bugs at home, on your person, or in personal belongings
- Having signs or physical symptoms as a result of bed bugs, such as bites
- Any knowledge of bed bug activity within your household
- Undergoing active treatments to remove bed bugs from your home or apartment (preventative treatments do not count as "activity")

The best strategies to keep bed bugs from spreading are prevention, early detection and rapid/thorough treatment. If you need any further help on how to control or detect bed bugs, please visit www.epa.gov/bedbugs for more information. By signing and dating this form, I am acknowledging that I am not aware of any bed bug "activity" and that if I should become aware of "activity" that I will let the counselor or the counseling office know immediately upon discovery. I will follow the recommended 90 day waiting period of experiencing no "activity" before returning to the counseling offices. Counseling does not have to be interrupted as it can be continued either off sight or via Skype until the situation has been resolved. If at any time, you would like to withdraw your signed consent to this disclosure agreement, you may do so by written notice or by e-mail.

_____

Client signature and date