New Client Intake Packet

For Counseling Services with Anna

Please complete one packet per person attending therapy. Bring the completed packet(s) with you to your first appointment, or scan and email to Anna (anna@renovationcounseling.com).

New Client Intake Form

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Primary Phone: _____ Home / Work / Cell (circle one)

Permission to leave voicemail? Yes / No Permission to text? Yes / No

Secondary Phone: _____ Home / Work / Cell (circle one)

Permission to leave voicemail? Yes / No Permission to text? Yes / No

Email:_____

Permission to email*? Yes / No

*Note: we cannot guarantee the confidentiality of email.

Birth date: _____/_____/_____Age: _____ Gender: Male / Female

Parent/Guardian(s) name(s) (if under 18): _____

Emergency contact (please include name, phone number, and relationship to you:

_____

Religious Affiliation, if any:_____

Ethnic/cultural heritage:_____

Referred by:_____

May I acknowledge this referral? Yes / No

Relational Information

Marital Status (please check all that apply):

☐Single

☐Dating (date) _____

☐Cohabitating (date) _____

☐Partnered (date) _____

☐Engaged (date) _____

☐Married (date) _____

☐Divorced (date) _____

☐Separated (date) _____

☐Previously married (year married/year divorced) _____

☐Widowed (date) _____

If you are currently in a relationship, on a scale of 1-10, where 1=very low quality and 10=very high quality, how would you rate your relationship? _____

Do you feel safe in this relationship? Yes / No

In the last year, have you experienced any significant life changes or stressors?

Yes / No

If yes, please describe: _____

_____

_____

Number and ages of children (if any): _____

_____

Counseling and Medical History

Have you utilized counseling services in the past? Yes / No

If yes, for what reason? _____

Was it helpful? Yes / No Why/why not? _____

If you are currently seeing another counselor, what is his/her name?

_____

Are you currently taking prescribed psychiatric medication(s) (such as antidepressant, antianxiety, or other medications)? Yes / No

If yes, please list: _____

Have you been prescribed psychiatric medication(s) in the past? Yes / No

If yes, please list: _____

How would you describe your present physical health? (circle one)

Poor / Unsatisfactory / Satisfactory / Very good / Excellent

Please list any persistent physical symptoms or health concerns (e.g. headaches, chronic pain issues, hypertension, diabetes): _____

_____

Sleep habits: Please check the relevant box(es) if you are experiencing any of the following: ☐Sleeping too little ☐Sleeping too much ☐Poor sleep quality ☐Disturbing dreams ☐Other (please specify): _____

On average, how many times per week do you exercise? _____

Eating habits: Please check the relevant box(es) if you have been experiencing any of the following in the past 6 months: ☐Eating less ☐Eating more ☐Binging ☐Restricting ☐Other (please specify): _____

Have you had significant weight change in the last 2 months? Yes / No

Do you regularly use alcohol? Yes / No How many days per week? _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

How often do you engage recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐I don't use recreational drugs

Legal Issues: Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past:

_____

Sexual Health: Do you have any concerns related to sex or your sexuality? Yes / No

If yes, what are your concerns?_____

_____

Do you have any current/past experiences with sexual abuse or trauma? Yes / No

Couple Concerns

Please check the relevant box(es) if you are experiencing any of the following:

☐Fighting/arguing
☐Communication problems
☐Feeling disconnected
☐Loss of fun
☐Sexual concerns
☐Sexual addiction
☐Parenting issues
☐Violence
☐Lack of intimacy
☐Spiritual issues
☐Money conflicts
☐Alcohol/Substance use
☐Abuse (physical, emotional, sexual, verbal)
☐Infidelity (sexual or emotional)
☐Other betrayal of trust
☐Other: _____

Comments: _____

_____

Individual Concerns

Please check the relevant box(es) if you have experienced any of the following:

☐Sadness
☐Crying
☐Hopelessness
☐Guilt
☐Mood swings
☐Fear/Nightmares
☐Flashbacks
☐Obsessions
☐Anxiety
☐Panic attacks
☐Suicidal thoughts
☐Suicidal acts
☐Hurting self
☐Hurting others

☐Anger/rage
☐Abuse (in childhood)
☐Abuse (in adulthood)
☐Distracted
☐Loneliness
☐Grief/loss
☐Work issues
☐Family/relationship difficulties
☐Spirituality issues
☐Alcohol/ substance use
☐Another's alcohol/ substance use

☐Irritability
☐Loss of pleasure
☐Sleep problems
☐Eating problems
☐Self-esteem/ body image problems
☐Phobias
☐Hallucinations
☐Unexplained memory lapses
☐Unexplained losses of time

Comments: _____

_____

_____

Client Signature: _____ Date: _____

Therapy Agreement and Informed Consent

Please initial where indicated.

I have read and have had explained to me the following materials pertaining to therapy. My therapist has offered me the following or I viewed it online:

_____ Privacy Notice (HIPAA)

I believe I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.

I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of both parties. *Please check the appropriate box(es)*

☐Individual Therapy ☐Family Therapy

☐Couples Therapy ☐Group Therapy

With enough knowledge, and without being forced, I enter into therapy with this therapist. I will keep my therapist fully informed about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur and to work through them in my long-term interest. Our goals may have changed in nature, order of importance, or definition.

Cancellation Policy

I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call my therapist to let him/her know. If I need to cancel or reschedule an appointment, I will give my therapist at least 24 hour's notice to avoid a cancellation fee.

_____I understand that cancelling a session with less than a 24-hour notice will result in a cancellation fee of $50.

_____ I understand failure to attend a session without giving notice (no show) will result in a cancellation fee equivalent to the full session fee.

_____I understand that after the first instance of a late cancellation or failure to attend a session, I will be required to keep an active credit card on file.

Exceptions for unforeseen or unavoidable situations are at the discretion of Renovation Counseling.

Payment Policy

Renovation Counseling is a self-pay counseling center, which allows clients to be seen without the involvement of an insurance company. By paying without insurance, you protect your privacy, avoid being given an insurance-mandated diagnosis in order to receive counseling services, and are more in control of the services you receive.

_____ I understand I may be able to receive reimbursement through my insurance provider's out-of-network benefits, flexible spending account (FSA), or health savings account (HSA). If I choose to do so, Renovation Counseling can provide me with an itemized receipt of services. I understand that if I wish to use any of these health benefits, it is my responsibility to verify coverage and submit any invoices for reimbursement. **I understand that, even if I use out-of-network, FSA, or HSA benefits, I am responsible to pay for my session in full at the time of service, or I may prepay for sessions.**

Fees

- $80 per 50-minute session before 4 pm
- $90 per 50-minute session 4 pm or later
- $120 per 80-minute session before 4 pm
- $135 per 80-minute session 4 pm or later
- $160 per 105-minute session before 4 pm
- $180 per 105-minute session 4 pm or later

_____ I understand that Renovation Counseling may increase the cost per session, but that I will be notified at least 30 days in advance of any rate increase.

Cell phone/Email/Fax Communication

If I choose to use email or a cell phone for communication, I understand it may compromise the confidentiality of my information in ways my therapist cannot control. I also understand my therapist may share a printer with other therapists and that those therapists will work together to ensure my privacy to the best of their ability.

_____ I understand the security of client information is not guaranteed when information is left on a voicemail, texted or emailed.

Case Consultation

_____ I give permission to this therapist to present my case in consultation with other professionals or consultants and Renovation Counseling therapists, who are bound by the legal framework of privacy and confidentiality, for professional development and

guidance purposes. I understand that this agreement will become part of my record of therapy.

Supervision

_____ I understand that my therapist is in the process of full licensure and, as such, is required to receive supervision for his/her work. I grant permission for my therapist to discuss my sessions with his/her supervisor as a condition of my treatment.

Emergency Procedure

In the event of a life-threatening emergency, I should call 911. If I have another crisis that cannot wait I am aware I can call the Crisis Connection at 612-379-6363. If I have a crisis plan with my therapist, I will follow that first.

Inactive Records

Your complete record will be retained for seven years after you have completed treatment. At the end of seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit (or for minors from the date they reach 18). Should there be any further direct client contacts the counting period will begin again at the date of new service.

Confidentiality Statement

Under the rules governing Marriage and Family Therapists in the state of Minnesota, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services except as follows.

- When the Board of Marriage and Family Therapy is reviewing a therapist. The Board shall be allowed access to records of a client treated by a therapist under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or licensee shall first delete data in the record that identifies the client before providing it to the board.

- When disclosure is required by state law like prenatal exposure to drugs and alcohol, reports of child abuse and neglect and vulnerable adults abuse and neglect.

- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.

- When the person, employee, or associate is a defendant in a civil, criminal, or disciplinary action arising from the therapy.

- When the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in that person's behalf.

- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

All other private information must be disclosed only with the informed consent of the client.

Minnesota Mental Health Bill of Rights

- Expect that a therapist has met the minimal qualifications of training and experience required by state law.

- Examine public records maintained by the Board of Marriage and Family Therapy, which contain the credentials of the therapist.

- You may file a complaint with the Office of Mental Health Practice, 2829 University Avenue SE, Suite 340, Minneapolis, MN 55414-3239. Their phone numbers are (612) 617-2105; TTY: (800) 627-3529; and fax: (612) 617-2103.

- You, the client, are billed directly for services, or your insurance coverage may be billed with your permission.

- You have a right to reasonable notice of changes in services or charges.

- You have the right to receive a summary, in plain language, of the theoretical approach used by us in working with clients.

- You have the right to complete and current information concerning our assessment and recommended course of treatment, including the expected duration of treatment.

- You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner working with you;

- Your records and transactions with us are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.

- You have the right to be allowed access to records and written information from records in accordance with Minnesota statutes.

- You should know that other services may be available in the community. To find out about such services, you may call First Call for Help at 651-291-0211.

- You have the right to choose freely among available practitioners, and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

- You have a right to coordinated transfer when there is a change in the provider of services.

- You may refuse services or treatment, unless otherwise provided by law.

- You may assert these and other rights without retaliation.

My signature on this Therapy Agreement and Informed Consent indicates that I:

- **Have reviewed, understand, and consent to the policies and information above, and**
- **Consent to participate in therapy at Renovation Counseling**

Client Signature: _____ Date: _____