Mountain Wolfe Counseling & Wellness LLC

Intake Form

Please print clearly. Please fill out form completely. Readmit: ___ Yes ___No

Date: ___________ **Client's Social Security #:**______________________ **Case #:** ______________

Client's *Legal* Last Name: _____________________ ***Legal* First Name:** _________________ **M.I.** ____

Address: __________________________________ **City:** _______________ **State:** ______ **Zip:** ______

Tel. (home) ______________________ (work)______________________ (cell) ___________________

OK to leave messages? Home: ___Yes ____No **Work:** ___Yes ___No **Cell:** ___Yes ___No

Email Address: ____ **Can Emails be sent:** __**Y** __**N**

Birthdate: ____/____/_____ **Age:**______ **Gender:** ___F ___M **Race:** ______________________

Highest level of education: ____

Name of Spouse/Guardian: _______________________________ **Phone:** _________________________

Address: ____________________________________ **City:**_______________ **State:** _____ **Zip:** _______

Emergency Information:

In case of emergency, contact:

Name (1) __________________________________ Relationship _________________ Phone _____________

Address ___________________________________ City _________________ State _____ Zip ________

Name (2) __________________________________ Relationship _________________ Phone _____________

Address ___________________________________ City _________________ State _____ Zip ________

Physician ____ Phone _______________________

Address ___________________________________ City _________________ State _____ Zip ________

Can your PCP be contacted for continuity of care, if needed: _____Yes ______Refused

Employment Information

Client/Guardian: Place _________________________________ Occupation ___________________ Hrs. ____

Spouse: Place _________________________________ Occupation ___________________ Hrs. ____

Referral Source

How did you hear of Mountain Wolfe Counseling & Wellness LLC ?

____

Address ______________________________________ City________________ State _____ Zip _________

Phone ______________________________________

Primary reason(s) for seeking services:

___Anger management ___Anxiety ___Coping ___Depression

___Eating Disorder ___Fear/phobias ___Mental confusion ___Sexual concerns

___Sleeping problems ___Addictive behavior ___Alcohol/drugs ___Past Trauma

___Other mental health or behavioral concerns (specify) ____________________________________

How old were you when you first felt these symptoms? _____________________________________

Any Additional information that would assist in understanding your concerns or problems? _________

____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___Aggression/Hostility
___Physical
___Verbal
___Panic Attacks
___Emotional Outbursts
___Alcohol abuse/dependence
___Anger
___Avoiding people
___Eating disorder
___Homicidal ideation
___Chest pain
___Speech problems
___Computer addiction
___Depression
___Trembling
___Difficulty getting along with
___Family
___Friends
___Low energy

___Memory Impairment
___Higher than usual mood
___Drug dependence
___Racing thoughts
___Fatigue
___Gambling
___Loneliness
___Heart palpitations
___High blood pressure
___Low self-esteem
___Hopelessness
___Judgment errors
___Impulsivity
___Irritability
___Behavior problems
___Difficulty with intimate relationships
___Initiating
___Sustaining
___Obsessions

___Paranoid
___Overly Sensitive
___Phobias/fears
___Rapid speech
___Recurring thoughts
___Sexual addiction
___Sexual difficulties
___Sick often
___Worrying
___Withdrawing
___Distractibility
___Disorientation
___Suicidal thoughts
___Thoughts disorganized
___Disruptive (home/school)
___Elimination problems
___Gender issues/identity
___Career conflict
___Other (specify)
____

Describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) ____
____

Stressors: (Check all that apply)

___Anticipated retirement
___Birth of first child
___Birth of a sibling
___Breakup of relationship
___Change in residence
___Change of employment
___Change of school
___Job dissatisfaction
___Lawsuit
___Parental Discord
___Retirement

___Arrest
___Chronic illness
___Conflict w/boss
___Conflict w/teacher
___Death of parent
___Financial difficulties
___Engagement
___Job layoff
___Marital discord
___Personal Injury
___Unemployment

___Bankruptcy
___Court trial
___Conflict w/child
___Death of a child
___Death of spouse
___Divorce
___Family conflict
___Job stress
___Marital separation
___Pregnancy
___Upcoming surgery

___Becoming a parent
___Change in financial status
___Conflict w/co-worker
___Death of a friend
___Death of grandparent
___Divorce of parents
___Illness (child/parent)
___Job termination
___Marriage
___Abuse (physical, sexual, verbal)
___Crime (witness/victim)

What areas of your life are being affected by the above?

Social
___Unable to form or maintain friendships
___Withdrawal from family and friends
(excessive desire to be alone)
___Increased conflict with others
___Loss of interest in social activities
___Phobias

Occupational
___Unable to maintain job
___Absenteeism
___Conflicts with co-workers
___Tardiness
___Reduced productivity
___Disciplinary action for poor performance

Affective Distress
___Crying spells
___Irritability

Physical
___Decreased energy/fatigue
___Difficulty getting out of bed or insomnia

Case # ____________________

___Anger/rage
___Disorganized thoughts
___Feeling overwhelmed with emotions
___Emotional meltdowns/breakdowns
___Worrying that interferes with the ability to concentrate
___Memory problems
___Concentration problems
___Decreased/Increased appetite
___Substantial weight loss or gain
___Physical complaints (headaches, stomachaches, etc.)
___Frequent illness

Family Information

Your current relationship status:

___Single ___Divorce in process ___Unmarried, living together ___Legally married
___Separated ___Divorced ___Widowed ___Annulment
___Engaged ___Other ____

If married, date of marriage: ________ # of times married: ______ # of times divorced: ______

Assessment of relationship with significant other (if applicable) ___Good ___Fair ___Poor ___N/A

Name	Age	Highest level of education	Occupation?	Living? (Yes or No)	Living with you? (Yes or No)
Mother: __________________	___	______	___________	_____	_____
Father: __________________	___	______	___________	_____	_____
Spouse: __________________	___	______	___________	_____	_____
Children: _________________	___	______	___________	_____	_____
__________________	___	______	___________	_____	_____
__________________	___	______	___________	_____	_____
__________________	___	______	___________	_____	_____

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives)

Please specify relationship:

Relationship	Name	Age	Living? Yes/No	Living w/you? Yes/No
_________________	___________________________	_____	______	_______
_________________	___________________________	_____	______	_______
_________________	___________________________	_____	______	_______
_________________	___________________________	_____	______	_______

Parental Information (Check those which apply)

____Parents legally married ____Parents separated ____Parents divorced
____Mother remarried # of times:____ ____Father remarried # of times: ____

Special circumstances (e.g., raised by person other than parent) ___________________________________

Counseling/Prior Treatment History (Information about client past and present)

	Yes	No	When	Where	Overall experience
Mental Health Counseling	___	___	__________	___________	_______________________
			__________	___________	_______________________
Suicidal thoughts/attempts	___	___	__________		
Drug/Alcohol treatment	___	___	__________	___________	_______________________
M.H. Hospitalizations	___	___	__________	___________	_______________________
Involvement w/self-help Groups (AA, al-alnon, etc.)	___	___	__________	___________	_______________________

Any immediate family in treatment currently? If yes, whom and where? __________________________

Previous mental health diagnosis(es): ____

Permission to contact Prior Mental Health professionals/hospitals? ___Yes ___No ___N/A

Development
Are there special, unusual, or traumatic circumstances that affected your development? ___Yes ___No
If Yes, please describe____
Has there been history of child abuse? ___Yes ___No If Yes, which? ___Sexual ___Physical ___Verbal
Other childhood issues ___Neglect ___Inadequate nutrition ___Poor health ___Other:________________
Comments regarding childhood development____
____

Social Relationships
Check how you generally get along with other people (check all that apply)
___Affectionate ___Aggressive ___Avoidant ____Fight/argue often ___Follower
___Friendly ___Leader ___Outgoing ____Shy/Withdrawn ___Submissive
___Other (specify)____
Do you have supportive friendships? ___Yes ___No
Sexual orientation__________________________Comments________________________________
Sexual dysfunctions? ___Yes ___No If Yes, describe: _________________________________
Any history of being abused by others? ___Yes ___No If yes, what type(s) of abuse?
___Emotional ___Sexual ___Physical ___Verbal ___Other: ______________________________
Any current behaviors or history as sexual perpetrator? ___Yes ___No
If yes, describe ____
Do you have a history of social problems (e.g. bullying, awkward social interactions)___________________
____

Cultural/Ethnic
To which cultural or ethnic group do you belong? _____________________________________
Are you experiencing any problems due to cultural or ethnic issues? ___Yes ___No
If Yes, describe____
Other cultural/ethnic information____

Spiritual/Religious
How important to you are spiritual matters to you? ___Not at all ___Little ___Moderate ___Much
Are you affiliated with a spiritual or religious group? ___Yes ___No
If Yes, describe ____
Were you raised within a spiritual or religious group? ___Yes ___No
If Yes, describe ____
Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No
If Yes, describe ____

Current Legal Status

Are you involved in any active cases (traffic, civil, criminal)? ___Yes ___No
If Yes, please describe and indicate the court and hearing/trial dates and changes________________________
____
Are you presently on probation or parole? ___Yes ___No
If Yes, please describe____

Are you: ☐ voluntarily attending therapy? ☐ Court ordered to therapy?

Past Legal History

Traffic violations ___Yes ___No DWI, DUI, etc. ___Yes ___No
Criminal involvement ___Yes ___No Civil involvement ___Yes ___No
If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education (Fill in all that apply)

Currently enrolled in school ___Yes ___No
___High school grad/GED Average school grades (current or previous)_________________________
___Vocational Number of years ___ Graduated ___Yes ___No Major_________________________
___College Number of years ___ Graduated ___Yes ___No Major_________________________
___Graduate Number of years ___ Graduated ___Yes ___No Major_________________________
Other training____
Special circumstances (e.g., learning disabilities, gifted) _______________________________________

Employment (Begin with most recent job, list job history)

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: __FT __PT __Temp __Laid-off __Disabled __Retired __Social Security __Student __Other

Military

Military experience? ___Yes ___No Combat experience? ___Yes ___No
Branch _______________________________ Discharge date _______________________________
Type of discharge ______________________ Rank at discharge ____________________________

Relative family member in the service? ____Yes ____No Who?_____________________________

Leisure/Recreational/Interests/Social

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, social organizations, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health Condition (Check any problem areas you have or have had)

Case # ____________________

For each illness listed below, choose a single answer that best describes your health history.

Condition	Currently	In Past	Never	Condition	Currently	In past	Never
Abortion				Loss of consciousness			
Anemia				Memory loss			
Appetite change				Numbness			
Arthritis				Pain (daily, longer than 2 weeks)			
Asthma				Palpitations			
Back pain				Paralysis			
Blood in stool				Rheumatic fever			
Blurred vision				Seizures			
Caffeine use				Shortness of breath			
Chest pain				Skin disease			
Chicken pox				Sleep apnea			
Chronic cough				Sleep difficulties			
Colitis or irritable bowel				Stroke or TIA			
Confusion or disorientation				Swallowing difficulty			
Constipation				Dental problems			
Diabetes				Thyroid disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or indigestion			
Emphysema				Urination difficulty			
Fainting				Sexually transmitted disease			
Glaucoma				Weakness			
Head injury				Recent Weight gain			
Headaches (frequent)				Recent Weight loss			
Hearing loss				Malnutrition			
Heart disease				Epilepsy			
Miscarriage				HIV/AIDS			
Infertility				Hepatitis			
Low libido				Energy level change			
Multiple sclerosis				Other			

List any current health concerns: ____

List any recent health or physical changes:____

Please list all of your current prescription and non-prescription (over-the-counter) medications:

Case # ______________________

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule	What dose do you take, and how often?	When was the most recent dosage change?	Prescribing Doctor

Please list all medication that you have taken <u>in the past</u>.

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?	Prescribing Doctor

Will you sign for permission to contact your prescribing doctor, if not your PCP? __ Yes __ No __N/A

Describe your overall compliance with the above medications ____
____

Please list all nutritional and herbal supplements that you currently take: ______________________________
____

Medication Allergies ____
Have you ever had any bad reactions (made you feel worse) to prior medications (if so, specify):
____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	____/week	____________________	____________________
Lunch	____/week	____________________	____________________
Dinner	____/week	____________________	____________________
Snacks	____/week	____________________	____________________

Additional comments on nutrition: ____
____

Do you feel suicidal at this time? ___Yes ___No Do you feel homicidal at this time? ___Yes ___No
If Yes, explain ____

Are you currently involved in any risk taking behaviors? ___Yes ___No
Please describe ____
____

List family history of mental illness/substance abuse:

Case # ____________________

Mother=MO Father=FA Sibling=S Grandmother=GM Grandfather=GF

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Suicide Attempt			
Death by suicide			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your ability to function at work or home?
If yes, please explain: ____

____

Chemical Use History – Have you EVER used any of the following?

Drug	Method of use/amount	Frequency of use	Age of first use	Age of last use
Alcohol				
"Meth"amphetamines				
Barbiturates				
Valium/Librium				
Cocaine/Crack				
Heroin/Opiates				
Marijuana				
PCP/LSD/Mescaline				
Inhalants				
Xanax, Klonopin, Ativan				
Caffeine				
Nicotine				
Over-the-Counter				
Prescription drugs				
Other				

Substance(s) of preference

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

Describe when and where you typically use substances: _____________________________

____

Describe any changes in your use pattern: ______________________________________

Case # ____________________

____

Describe how your use has affected your family or friends (include their perceptions of your use):
____

Reason(s) for use:
___Addicted ___Build confidence ___Escape ___Self-medication
___Socialization ___Taste ___Other:____

How do you believe your substance use affects your life? ____
Who or what has helped you in stopping or limiting your use? ____________________________________

___Has your use of alcohol or drugs interfered with your obligations at work?
___Has your use of alcohol or drugs interfered with your obligations at school?
___Has your use of alcohol or drugs interfered with your obligations at home?

___Have you used alcohol or drugs while driving a vehicle or operating machinery?
___Have you ever been arrested as a result of drinking or using drugs?
___Have you continued to use alcohol/drugs despite having problems caused by the effects of alcohol/drugs?

___Have you ever used more alcohol/drugs in order to achieve the desired effect?
___Has there become a markedly diminished effect with the continued use of the same amount of the substance?
___Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?

___Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
___Have you attempted to cut down or control the amount of drinking or drug use without success?
___Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?

___Have you given up or reduced important social, occupational, or recreational activities because of your use of alcohol or drugs?
___Have you continued to use alcohol or drugs despite knowing physical, psychological, or legal problems are likely to occur?

Is there anything further that you would like to add in regard to your overall history?
____
____

Goals for Therapy

Please list your goals for therapy. In other words, what do you want to see changed by coming to therapy?
____
____

By signing below, I am indicating that the above information is accurate to the best of my ability.

____ _____________________________
Client Signature Date

For Office Use Only:

____ _____________________________
Therapist's Signature/Credentials Date

Revised 12/27/2024

Case # ______________________

Mountain Wolfe Counseling & Wellness LLC

Informed Consent for Therapy Services

COUNSELOR-CLIENT SERVICE AGREEMENT

Client Name:___________________________________ DOB:_________________

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary of where in the office information can be found about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. A copy of the HIPAA, PHI, and patient rights will be provided to you upon request. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS
Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full amount that would have been due for the missed appointment [unless we both agree that you were unable to attend due to circumstances beyond your control]. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES
The standard fee for the initial intake is $115.00 and each subsequent session is $100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash, debit or credit card. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document that is available to you in a binder in the office. You can have your own copy of your rights at any time you request. Please remember that you may reopen the conversation at any time during our work together regarding confidentiality and your rights.

PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms. You are also acknowledging that you have been offered a copy of Notice of Privacy and HIPPA documents.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

Date _____________________________________

Therapist Signature / Credentials:____

Date _______________________________________

Case # ____________________