Wellness Counseling

Adult Intake Form

Today's Date: _____

Patients Full Name: _____Birth Date:_____

Have you experienced any of the following?

Depression	Mood swings	Anxiety life changes	Attention/Focus
Loss of loved one	Legal issues	Self harm	Relationship issues
Sleep disturbance	Loneliness	Racing thoughts	Crying spells
Financial worries	Sexual problems	Medication Changes	School problems
Substance use	Anger	Guilt/Shame	Fears
Job stress	Decreased activity	Loss of interests	Appetite changes

Other symptoms not mentioned: _____

_____

How long have you been experiencing these symptoms?

_____

_____

Have you had thoughts or hurting yourself? ☐No ☐Yes, please explain _____

_____

_____

Have you had thoughts of killing yourself? ☐No ☐Yes, please explain _____

_____

Treatment Goals:

What do you hope to gain from therapy?

_____

_____

Family History:

	Name	Occupation	Age	Describe relationship
Mother				
Father				
Step parent				
Step parent				
Spouse				

Names and ages of children:

Name Ages Describe relationship

_____

_____

_____

_____

Please describe any past counseling?

_____

_____

Work History

What is your current occupation? _____ Do you like your job? ☐ No ☐ Yes

Previous employment for past 10 years

Company	Occupation	How long	Why terminated

Education History

School	Years	Graduated/Degree

Financial Status

Source of income: _____

History of financial difficulties? _____

_____

Medical History:

What is the name of your primary care physician? _____

Address: _____ Phone: _____

Date of your last medical examination: _____

Please list any medical conditions? _____

_____

_____

_____

Please list any medications you take on a regular basis: _____

_____

_____

Have you ever been admitted to a mental health hospital? ☐ No ☐ Yes

Name of facility	Month/date	Length of stay	Reason for admission

Alcohol History:

Age of first use of alcohol	Drinking preference	Quantity	Frequency

Drug History

Type of drug				
Age of 1st use				
Quantity				
Frequency				

Substance Inpatient/Outpatient/Residential

Name of facility	Month/Date	Length of stay	Reason for admission

Other History:

Have you ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe: _____

_____

_____

_____

Have you ever experienced any serious emotional losses (such as a death of or physical separation from a child, parent, loved one, etc.)? If yes, please explain: _____

_____

_____

Has there ever been any type of legal issues? ☐No ☐Yes, please explain_____

_____

_____

Has there been any history of Child Protective Services (CPS) involvement? ☐No ☐Yes, please explain ___

_____

_____

_____

Finally, what are some of the things that are currently stressful to you and your family?

_____

_____

_____

_____

_____

_____

_____

_____

Wellness Counseling

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

_____ _____

Client or legal guardian (please print) Date

_____ _____

Signature of Individual or Legal Representative Date

Wellness Counseling
Consent for Treatment

I have chosen to receive mental health services in the form of behavioral therapy for myself and/or my child from Wellness Counseling. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services
I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan
I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision
I understand there are certain circumstances which may require Wellness Counseling LLC provider to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies
I understand I may reach my Wellness Counseling provider at (734) 778-0663. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life threatening emergency situation, I may call 911.

I have read, discussed and understood all of the above.

_____ _____
Client or Guardian Signature Date

_____ _____
Witness Date

Wellness Counseling

1 Heritage Place, Suite 261
Southgate, Michigan 48195
Phone: (734) 778-0663
Fax: (734) 785-8328

Primary Care Physician Notification Release

Name of Patient: _____Date of Birth: _____

Name of Parent/Legal Guardian (if necessary): _____

Name of Physician: _____

Address: _____

CONSENT TO EXCHANGE INFORMATION

I, _____, agree to release my, or my son's/daughter's medical records to the above named physician. I understand the purpose of, and agree to, providing this information to assist my physician in coordinating the necessary care between my behavioral health care provider and my primary care physician. I understand that such information may include my diagnosis and the current medications I, or my son/daughter, am/are taking.

I understand that my signature means that any change in medication during the course of my, or my son/daughter's treatment at Wellness Counseling LLC, will result in the communication with my primary care physician the specific medication and dosage.

_____ _____
Client/Parent/Legal Guardian Signature **Date**

_____ _____
Witness Signature **Date**

(Optional)_____(Initials) I DO NOT wish to exchange information with my primary care physician. I understand that I take full responsibility to communicate to my primary care physician my diagnosis, treatment, and any medications that I have been prescribed by Wellness Counseling LLC.

Reason(s) for not agreeing to exchange info:

☐**Chose not to disclose** ☐**Personal** ☐**Other**_____

FOR OFFICE USE ONLY

THERAPIST NAME/CREDENTIALS_____

PRIMARY DIAGNOSIS: _____ CODE_____

MEDICATIONS PRESCRIBED: _____

_____

DATES SENT TO PCP: _____