**THERAPY INTAKE PACKET (Child or Adolescent)**

**Included in this Packet:**

(1) Information & Consent Form

(2) Notice of Privacy Practices

(3) Acknowledgment of Receipt of NPP

(4) Telehealth Form

(5) Fee Agreement

(6) Assent Agreement for Minors

(7) Credit Card Authorization Form

**Instructions:**

*Before your child’s appointment:*

(1) Read and Sign/Date the ***Office Copy*** of the **Information & Consent Form**

(Keep the *Client Copy* that is printed for you)

(2) Review the **Notice of Privacy Practices (NPP)**

(3) Sign/Date the **Acknowledgment of Receipt of NPP**

(4) Sign/Date Telehealth Form

(5) Fee Agreement and Recording Consent

(6) Assent Agreement for Minors

*Bring to your child’s appointment:*

1. ALL signed and completed forms that do not indicate ‘Client Copy’
2. Insurance Card
3. Photo ID (Parents)
4. Divorce Decree if applicable

If you have any questions regarding these forms, please call (469) 573-3031 or email insightcounselingservices.tx@gmail.com

**Information and Consent Form (Minor)**

[Client Copy – Keep for your records]

**Services Provided**

Rochell Torris, LPC and Insight Counseling Services, PLLC offers a variety of individual, family, and group therapy services provided by Licensed Professional Counselors.

**Psychotherapy**

Psychotherapy can have both risks and benefits. The therapy process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, psychotherapy has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reduction in your feelings of distress. But, there is no assurance of these benefits.

**Confidentiality**

In keeping with professional ethical standards and state and federal law, all services provided by our staff are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. We consult as needed within the staff of Insight Counseling Services, PLLC about the best way to provide the assistance that you might need. As required by psychological practice guidelines and current standards of care, we keep records of all therapy sessions. These records are stored securely consistent with federal and professional security standards for medical records.

Our professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately these situations are infrequent.

By signing this form you also give Rochell Torris, LPC and Insight Counseling Services, PLLC clinician’s permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. If you are suing someone or being sued, or if you are charged with a crime and you tell the court that you are a client, Insight Counseling Services PLLC or your clinician may then be ordered to show the court your records. Please consult your lawyer about these issues. In the event Rochell Torris, LPC is subpoenaed to testify in court, court cost will be paid upfront by the client to clear the clinician’s calendar per day. Please consult with your clinician if you have any questions about confidentiality.

**Information and Consent Form, cont.**

[Client Copy]

**Policies for Your Child**

This is not an emergency or crisis intervention facility. Clinicians are not available 24 hours per day; however, you can always leave a message at (469-573-3031) and the Office Manager will have your clinician contact you as soon as possible. In the event of an emergency or crisis

between scheduled appointments, go to the nearest emergency room or seek help by the Suicide Crisis Center 24-Hour Line at 214-828-1000 (all ages), or call 911 if it is a life-threatening situation.

Your initial session is an assessment session, devoted to gathering information about you, your current difficulties, and biographical information that will assist your clinician in developing a treatment plan and interventions that are specific to you. If at any point it is determined that other services are more suitable or would be beneficial in addition to your treatment, we will help you obtain assistance from appropriate providers. Noncompliance with treatment could result in the termination of services.

Sessions last 50 minute. Please arrive on time for your appointments. If you are unable to keep your appointment, please call to cancel at least 24 hours in advance. If you miss or cancel an appointment without giving 24 hours’ notice, you will be required to pay a fee for the missed appointment according to the time that was scheduled. Repeated cancellations or missed appointments may result in the termination of services.

Our goal is to provide the most effective psychotherapeutic experience. If you feel that your clinician is not a good match for you, we encourage you to discuss this matter with your current clinician. Alternatively, you can speak with the Clinical Director, Rochell Torris, LPC. Either of the above may explore a shift in approach or facilitate a transfer to a different clinician, if necessary.

In general, you may review your child’s records at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. However, you may not examine records created by anyone else and sent to us.

**Psychiatric Consults and Medication**

We can provide you with a psychiatric referral if deemed necessary. Your clinician may have you sign a release to enable us to consult with your Psychiatrist.

**Information and Consent Form, cont.**

[Client Copy]

**Use of electronic communications (email / social media)**

Please be aware that e-mail or social media may not be private or confidential and may not be read by the recipient in a timely fashion.

**Consent**

By signing, I agree to be treated by a qualified clinician. I understand I have the right **not** to sign this form. My signature indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my rights. I understand that I can choose to discuss my concerns with the clinician before I begin treatment. I understand that after my treatment begins I have the right to withdraw my consent at any time, for any reason. However, I will make every effort to discuss my concerns with the clinician before ending my treatment.

**Please sign below to indicate that you understand and agree to participation in psychotherapy in accord with the policies outlined above.**

**Confidentiality and Exceptions to Confidentiality**

Therapy comes with an assumption that what is said by you is kept confidential by your therapist. Certain laws and prudent professional practice affect your therapist’s choice to keep your information completely confidential. Please read the following carefully, discuss all concerns and questions with your therapist, and initial as appropriate. The following is not intended to be a guarantee that other circumstances will not arise which may impact confidentiality. You deserve to have exceptions to confidentiality discussed with you, but your legal rights are affected by outside influences, such as changes in the law.

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that, if I am in imminent danger of harming myself or others:

  \_\_\_\_\_My therapist may notify medical or law enforcement personnel without my permission.

  \_\_\_\_\_I give my therapist permission to also notify the following person(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  \_\_\_\_\_I understand that my therapist is required by law to report suspected child or elder abuse (65)

  \_\_\_\_\_I understand that the use of third party payment resources often require reporting by my therapist of otherwise confidential information, such as diagnosis of a mental health disorder.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Client’s Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name

**Consent to Treatment**

By signing below, I agree to allow my child to be treated by a qualified therapist.

I understand I have the right **not** to sign this form. My signature below indicates I have read and discussed this agreement; it **does not** indicate that I am waiving any of my or my child’s rights. I understand I can choose to discuss my concerns with the therapist before my child begins therapy. I understand that after therapy begins I have the right to withdraw my consent to my child’s psychotherapy at any time, for any reason. However, I will make every effort to discuss my concerns with the therapist before ending the treatment.

I understand that no specific promises have been made to me by the therapist or staff about the results of my child’s psychotherapy.

Information obtained during my child’s treatment will be confidential and privileged except for the limitations noted above.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ parent and / or managing conservator (guardian) for

 Parent/Guardian’s Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow my child to enter into psychotherapy at

 Child’s Printed Name

Rochell Torris, LPC and Insight Counseling Services, PLLC in accord with the policies outlined above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Witness to Signature Date

**Notice of Privacy Practices (NPP) (Minor)**

[Client Copy – Retain for your records]

***This notice describes how mental health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.***

**WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:**

* For Treatment. For example, we may give information about your psychological condition or assessment to other health care providers, such as your child’s pediatrician or another psychologist, to facilitate your child’s treatment, referrals or consultations.
* For Payment. For example, a health care provider may contact your insurer to verify what benefits your child is eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
* For Healthcare Operations For example, we may give information to University or professional mental health and training organizations to review the quality of care provided, for performance improvement or for the training of health professionals. Other examples could include audits and administrative services, and case management and care coordination.
* For Appointments and Services to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.
* To Individuals Involved in a Child’s Care. For example, your parents, if you are a minor, or your conservator.
* With your written authorization we *m*ay use or disclose mental health information for purposes not described in this Notice*.*

**WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:**

* As Required by Law when required or authorized by other laws, such as the reporting of child abuse, elder abuse, disabled or dependent adult abuse.
* For health oversight activities to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
* In Judicial Proceedings in response to court/administrative orders, subpoenas, discovery requests or other legal process. If Rochell Torris, LPC and Insight Counseling Services, PLLC and/or your clinician is subpoenaed to appear in court and provide testimony regarding our knowledge and experience of you and our assessment, we will assert privilege on your behalf. Nevertheless, if the judge insists we testify, we will testify truthfully and honestly to our thoughts and professional opinion.

**Notice of Privacy Practices, cont.**

[Client Copy – Retain for your records]

* To Public Health Authorities to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.
* To Law Enforcement for example, to assist in an involuntary hospitalization process.
* To the State Legislative Senate or Assembly Rules Committees for legislative investigations.
* For Research Purposes subject to a special review process, and the confidentiality requirements of state and federal law.
* To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.
* To Protect Certain Elective Officers including the President, by notifying law enforcement officers of potential harm.

**YOU HAVE THE FOLLOWING RIGHTS:**

* To Receive a Copy of this Notice when you obtain services for your child.
* To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about your child for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
* To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your child’s record. You must put your request for a copy of your child’s records in writing. If you are denied access to your child’s mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
* To Request an Amendment and/or Addendum to your Child’s Mental Health Record**.** If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your requestor an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.
* To Receive an Accounting of Certain Disclosures we have made of your child’s mental health information. You must put your request for an accounting in writing.

**Notice of Privacy Practices, cont.**

[Client Copy – Retain for your records]

* To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

**CHANGES TO THIS NOTICE:** Rochell Torris, LPC and Insight Counseling Services, PLLC reserves the right to change or revise this Notice. If a revision is made to our policies and procedures, a revised copy will be posted in the office and a copy will be provided to you upon request.

**CONTACT INFORMATION**: If you have any questions about this Notice, please contact the office manager, Rochell Torris, LPC and Insight Counseling Services, PLLC at 6010 W. Spring Creek Pkwy, Suite 247, Plano, Texas 75024, or by telephone at 469-573-3031*.* If you believe your privacy rights have been violated, you may contact the Texas Behavioral Health Executive Council at 1-800-821-3205. You may also send a written complaint with the form listed below: <https://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf>.

**You will not be penalized for filing a complaint.**

**Acknowledgment of Notice of Privacy Practices**

[Office Copy]

Rochell Torris, LPC and Insight Counseling Services, PLLC notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice may be obtained through the office manager.

I acknowledge that I have received the Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Client or Client’s Representative Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Name*

*Interpreter (if applicable)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Teletherapy Informed Consent Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(client)* hereby consent to engage in teletherapy with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Clinician)*. I understand that “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

3. You understand that this teletherapy occurs in the state of Texas, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her Texas office.

4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

**Telehealth Informed Consent Form (Cont.)**

7. I accept that teletherapy does not provide emergency services. During our first session, the clinicianand I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.

9. I understand that while email may be used to communicate with the clinician*,* confidentiality of emails cannot be guaranteed.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client (or Guardian’s) Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**Therapy Fee Agreement and Recording Consent (Minor)**

[Office Copy]

**Financial Responsibility**

Payment is due at the time of service unless other arrangements are made in advance with the Director or Office Manager. For my child’s ongoing psychotherapy, I agree to pay **$\_\_\_\_\_\_\_\_\_\_\_\_** per session. I understand that Rochell Torris, LPC and Insight Counseling Services, PLLC may accept some insurance and/or self-pay. We make our best attempt to verify benefits where it applies. Information obtained is never a guarantee of payment. Client or responsible party agrees to pay if insurance denies payment. I understand that it is my responsibility to contact my insurance company to clarify benefits and reimbursement for services.

I understand that this regular fee will be charged for any additional professional services rendered for my child at my request, such as phone contacts with me or my child over 10 minutes, consults with other professionals, preparation of special forms, summaries, letters, etc. that are not related to my direct treatment. This includes paperwork for disability and legal matters.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Child’s Printed Name Parent or Guardian’s Printed Name*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Signature of Parent or Guardian Date*

**Assent Agreement for Meeting with My Counselor**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to meet with my counselor. Our meetings will last 45- 50 minutes. When we meet, we will mostly likely just talk, but we may also draw pictures, play games, or do other things to help this counselor get to know me better and understand my problems, thoughts, and goals.

I understand that my parent (or parents) or my guardian has a right to know how I am doing in counseling. I agree that this counselor may talk with my parent/guardian to discuss how I am doing. They may also talk about concerns and worries they may have about me. Or they may talk about things the counselor and I decide my parent/guardian needs to know about. Sometimes this counselor may meet with my parent/guardian without me. At other times we may all meet together.

The specific things I talk about in my meetings with the counselor are private. I understand this counselor will not tell others about the specific things I tell him or her. My counselor will not repeat these things to my parent/guardian, my teachers, the police, probation officers, or agency employees. But there are two exceptions. First, because of the law, the counselor will tell others what I have said if I talk about seriously hurting myself or someone else. The counselor will have to tell someone who can help protect me or the person I have talked about hurting. Second, if I am being seriously hurt emotionally, physically or sexually by anyone, this counselor has to tell someone for my protection.

I understand that I may not feel good about some things we may talk about in our meetings. I may feel uncomfortable talking to this counselor because I don’t yet know him or her very well. I may feel embarrassed talking about myself. Some of the things we talk about may make me feel angry or sad. Sometimes coming to meetings may interfere with doing other things I enjoy more. But I also understand that coming to counseling should help me feel better in the long run. I may find that I will trust this counselor and can talk about things that have been hard to talk to anyone else about. I may learn some new, important, and helpful things about myself and others. I may learn some new and better ways of handling my feelings or problems. I may feel less worried or afraid and come to feel better about myself.

Any time I have questions or am worried about my counseling, I know I can ask this counselor. My counselor will try to explain things to me in ways that I can understand. I also know that if my parent/guardian has any questions, the counselor will try to answer them. I understand that my parent/guardian can stop my coming to counseling if he or she thinks that is best. If I decide counseling is not helping me and I want to stop, this counselor will discuss my feelings with me and with my parent/guardian. I understand that the final decision about stopping is up to my parent/guardian.

**Assent Agreement for Meeting with My Counselor (Cont.)**

Our signatures below mean that we have read this agreement, or have had it read to us, and agree to act according to it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Parent Date

I, the counselor, have discussed the issues above with the minor client and his or her parent/guardian. My observations of their behavior and responses give me no reason, in my professional judgment, to believe that these persons are not fully competent to give informed and willing consent and assent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Counselor Date

**Credit Card Authorization Form**

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.

All information will remain confidential. All services must have a credit card on file.

(Cash, Check, and Credit Cards are accepted)

Card Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code (3-digit):\_\_\_\_\_\_\_\_

Amount to Charge: $ \_\_\_\_\_\_\_\_\_\_\_\_\_ (USD) I authorize Insight Counseling Services, PLLC/Rochell Torris, LPC to charge the agreed amount listed above to my credit card provided herein. I agree that Insight Counseling Services, PLLC/Rochell Torris may charge a $100 fee for missed or canceled appointments without 24 hour notice. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder- Print Name, Sign and Date Below:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Amount to charge is according to your individual insurance plan (copay or deductible amount) or self-pay. The late cancellation fee or no shows are charged at the full session rate. Late cancellations and no shows cannot be billed to insurances. Those fees are paid out of pocket by the client.\*

|  |
| --- |
| Intake Questionnaire |
| Today’s date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ month day year  |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Birth date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_month day year |
| Contact Information:Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎OK to phone 🞎OK to leave message 🞎OK to text Home or other phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎OK to phone 🞎OK to leave message Preferred E-mail address: (Please be aware that email might not be confidential.)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 OK to email and/or text regarding your appointment 🞎 OK to email an evaluation surveyregarding your experiences with Insight Counseling Services, PLLC |
| Preferred Method of Contact: 🞎Cell Phone 🞎Home Phone 🞎Email 🞎Mail🞎Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Emergency Contact:Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| SECTION A: Demographic Information |
| **(A1) Gender:** **🞎 Female 🞎 Male 🞎 Transgender 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(A2) Ethnicity:****🞎African🞎 Black / African-American****🞎Puerto Rican🞎Chinese / Chinese-American** **🞎East Indian / Pakistani🞎Filipino****🞎 Indian🞎Japanese / Japanese-American** **🞎Korean / Korean-American 🞎Latino / Latino-American / Hispanic****🞎 Mexican / Mexican-American🞎Middle Eastern** **🞎Native-American / Alaskan Native🞎Polynesian / Micronesian****🞎Vietnamese / Vietnamese-American 🞎White / Caucasian****🞎Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎Prefer Not to Answer** **🞎Multiracial/Multiethnic (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **(A3) Sexual Orientation:****🞎Bisexual 🞎Heterosexual 🞎Lesbian/Gay 🞎Questioning** **Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(A4) Relationship Status:****🞎Single 🞎Partnered 🞎Married 🞎Separated** **🞎Divorced🞎Widowed 🞎Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****If applicable, please list your current or former partner or spouse’s age and occupation:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **If applicable, how long have you / were you in this relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(A5) Educational Information: (check highest degree you have earned)****🞎GED🞎High School🞎Associates Degree🞎Bachelor’s Degree** **🞎Master’s Degree 🞎Doctoral Degree** **Schools Attended/Attending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Field(s) of study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **(A6) Occupational Information:****Are you currently employed? 🞎Yes 🞎No** **If yes, list your current occupation and employer below. If no, list your previous occupation and employer below.****Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(A7) Military Service:** **Are you a Veteran? 🞎 Yes 🞎 No** **If yes, what branch of military \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **(A8) Referred By: (check all that apply)****🞎 Self (see below) 🞎 Friend 🞎 Family Member 🞎 School** **🞎 Insurance Company 🞎 Medical Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **If Self, how did you hear about our services? 🞎Insight Counseling Services, PLLC Website****🞎Psychology Today 🞎Other Website:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****🞎 Business Card 🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| SECTION B: Presenting Concerns |
| **(B1) Briefly describe what brings you to Insight Counseling Services, PLLC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(B2) Approximately how long have these concerns been bothering you?****🞎 Day🞎 Week🞎Month🞎 Several months🞎 Year****🞎 Several years🞎 Most of my life**  |
| **(B3) How much do these concerns interfere with your:**  **Daily Routine: Very little : 1 2 3 4 5 : Severe** **Emotional Well-being: Very little : 1 2 3 4 5 : Severe** **Relationships/Activities: Very little : 1 2 3 4 5 : Severe** **Work / School: Very little : 1 2 3 4 5 : Severe** |
| SECTION C: Health History  |
| **(C1) Physician Information:(list name, address and phone number)** **Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C2) When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C3) Currently, how is your physical health?****⬜Poor ⬜ Unsatisfactory⬜Satisfactory ⬜Good ⬜ Excellent** |
|  **(C4) Have you had any serious accidents or injuries? ⬜ Yes (specify below) ⬜ No** **If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C5) Check any of the following symptoms that you have had, including dates as best you can:****🞎 Asthma \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Heart problems \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Chest problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 HIV+ / AIDS \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Cancer \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Joint / limb problems \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Chicken pox \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Liver / kidney problems \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Dental problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Other neurological problems \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Ear, nose or throat problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Rheumatic fever / strep infections \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Growth / endocrine problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Seizures / convulsions \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Gynecological / menstrual problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Serious accidents / fractures \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Head injury / loss of consciousness \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Skin problems \_\_\_\_\_\_\_\_\_\_\_\_****🞎 Hearing / vision problems \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Stomach or bowel problems / soiling \_\_\_\_\_\_\_\_\_****🞎 Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Urinary or bladder problems / wetting \_\_\_\_\_\_\_\_\_** |
| **(C6) Please list any other persistent physical symptoms or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **(C7) Do you regularly take any prescribed medications, over-the-counter drugs, supplements or alternative remedies to treat a medical condition? ⬜ Yes ⬜ No** **If yes, please list any medications you are currently taking, the condition for which the** **medication is taken, and the prescribing physician (if applicable):**  **(e.g., Prevacid30 mg, stomach ulcer, Family Doctor)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C8) Are you having any problem with your sleep habits? ⬜No problems ⬜Sleeping too much** **⬜Sleeping too little ⬜Poor quality of sleep ⬜Disturbing dreams****⬜Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C9) How many times per week do you exercise?****⬜ One or less ⬜ Two to four ⬜ Five or more** **For about how long do you exercise at a time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C10) Are you currently having difficulty with appetite or eating habits? Check all that apply.****⬜ No difficulty ⬜ Eating less ⬜ Eating more ⬜ Binging****⬜ Restricting ⬜ Significant weight change (gain or loss)****Please describe the nature of your eating habits or weight change: (e.g., frequency of eating patterns, how much weight lost and time frame, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(C11) Do you have any problems or worries about sexual functioning? Check all that apply.****⬜ No concerns ⬜ Lack of desire ⬜ Performance problem****⬜ Sexual impulsiveness ⬜ Difficulty maintaining arousal****⬜ Worried about sexually transmitted disease** **⬜ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| SECTION D: Mental Health History  |
| **(D1) Have you received counseling or psychotherapy in the past?****🞎 Yes (specify below) 🞎 No** **If yes, please explain, including when and with whom. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(D2) Are you a returning client to Insight Counseling Services, PLLC?****🞎 Yes (specify below) 🞎 No** **If yes, when did you receive services at Insight Counseling Services, and who was the mental health provider/clinician: (e.g., Fall 2011, Rochell Torris, LPC) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **(D3) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? 🞎 Yes (specify below) 🞎 No****If yes, please provide the mental health provider’s name and phone number:** **(e.g., Dr. Smith, 214-555-5555) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(You must complete a release of information form if you choose to have Insight Counseling Services, PLLC share information with this provider.)** |
| **(D4) Have you been diagnosed (currently or in the past) as having a psychiatric disorder? (e.g.,****anxiety disorder, mood disorder, learning disorder, post-traumatic stress disorder, eating disorder, personality disorder, etc.)****🞎 Yes (specify below) 🞎 No****If yes, please list the disorder(s) and approximately when the diagnosis was made:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **(D5) Have you been prescribed psychiatric mediation in the past?****🞎 Yes (specify below) 🞎 No****If yes, please list what medications, dosage, and when taken:**  **(e.g., Prozac, 20 mg, 2008-2010) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Were the medications helpful? 🞎 Yes🞎 No** |
| **(D6) Are you currently taking prescribed psychiatric medication, antidepressants, or other medications? 🞎 Yes (specify below)🞎 No** **If yes, please list any psychiatric medications you are currently taking and the prescribing****psychiatrist/physician: (e.g., Prozac, 20 mg, Family Doctor)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are the medications helpful? 🞎 Yes 🞎 No** |
| **(D7) Have you been hospitalized for psychiatric reasons?****🞎 Yes (specify below) 🞎 No****If yes, please specify reason for past hospitalization: (check all that apply)****🞎Psychological problems 🞎 Suicide thoughts / attempt** **🞎Dangerousness to others 🞎 Drug / Alcohol** **🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Was the hospitalization helpful? 🞎 Yes🞎 No** |

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| SECTION E: Family and Social Information |
| **(E1) Please list the members of your family (e.g., parents, siblings, relatives with whom you are close;*****list children in Question F2*): (e.g., Bob, father, living, 58, accountant)** **Name, Relationship to you, Living or Deceased Age (or age at time of death), Occupation****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(E2) Do you have children? 🞎 Yes 🞎 No**  **If yes, please list name, age and gender of children (indicate if step, foster or adopted child):**  **(e.g., Tommy, male, living, 9, 3rd grade, biological)****Name, Gender, Living or Deceased, Age/Grade, Biological/step/foster/adopted child****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **If yes, do you have full custody of your children? 🞎 Yes 🞎 No (specify below)** **If no, describe the custody arrangement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **(E3) Besides family members, approximately how many people can you count on right now for friendship and emotional support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **(E5) Is there any additional information about you, your current difficulties, special circumstances or** **challenges within your family, relationships, or educational or work environment that would be** **helpful for us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Thank you for completing the Intake Questionnaire.

Services Offered

50 minute session $100-150

Phone call (11-20 minutes) $30

Phone call (21-30 minutes) $40

Paperwork (FMLA, Disability, etc) $10/page

Court Involvement $2,000 initial and $300 for every hour of time dedicated (court, preparation, travel, etc.)