Grace Counseling Services, PLLC

**Intake Form**

*Please answer the following questions below. Please note: information you provide here is protected as confidential information and is only used for treatment purposes.*

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

 (First) (Middle Initial) (Last)

Name of parent/guardian (if client is under 18 years):

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

 (First) (Middle Initial) (Last)

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ☐Male ☐ Female

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Please list any children and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MailingAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? ☐Yes ☐ No

Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we email you? ☐ Yes ☐ No \*Please note: Email correspondence is not considered to be the most confidential medium of communication.

Referred By (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION:**

Have you previously received any type of mental health services? ☐Yes ☐ No
\*\* If yes, please provide previous therapists/psychiatrists and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously had any hospitalizations for mental health reasons?

☐Yes ☐No \*\* If yes, please explain and include treatment dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you currently taking any medications? ☐ Yes ☐ No
\*\*If yes, please provide current medications, dosages and prescribers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously taken medications? ☐ Yes ☐ No
\*\* If yes, please provide previous medications and dates discontinued: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any medical conditions? ☐Yes ☐ No
\*\* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How would you rate your current physical health?
☐ Very Good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How would you rate your current sleeping habits?
☐Very Good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How many hours per night do you sleep on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any physical exercise you engage in on a weekly basis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you experienced any recent changes in appetite? ☐ Yes ☐ No
\*\* If yes, please provide explanation of changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently experience any feelings of sadness, grief or depression?

☐Yes ☐ No \*\* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently experience any feelings of anxiety, panic attacks or phobias? ☐Yes ☐No

\*\* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you drink alcohol more than once a week? ☐Yes ☐ No
\*\* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you engage in any recreational drug use? ☐Yes ☐ No
\*\* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you experienced any significant life changes or stressful events recently? ☐Yes ☐ No

\*\* If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Counseling Information:**

Please tell us what brings you to counseling today

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

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What areas are you hoping to bring change or growth in?

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

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If you would like to list an emergency contact person please do so below. *By listing a contact you are giving us permission to contact this person in the case of an emergency.*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

In the chart below, please check if there is any family history of the following. If you select **yes** please indicate the family member’s relationship to you in the space provided.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Family Member** |
| ADHD |  |  |  |
| Alcohol/Substance Abuse |  |  |  |
| Anxiety |  |  |  |
| Depression |  |  |  |
| Domestic Violence |  |  |  |
| Eating Disorders |  |  |  |
| Gambling Problems |  |  |  |
| Homicidal Behaviors |  |  |  |
| Learning Disabilities |  |  |  |
| Obsessive Compulsive Disorder |  |  |  |
| Psychotic Symptoms |  |  |  |
| Schizophrenia |  |  |  |
| Suicidal Behaviors/Suicide Attempts |  |  |  |

*Grace Counseling Services PLLC*, provides Christian counseling services as well as evidenced based practices. Please tell us your preference for having Christian counseling incorporated into your therapy time.

* Yes, please include Christian counseling ☐ No, do not include Christian counseling

\*\*Our Code of Ethics does not allow us to be “friends” or “follow” clients on social media. You are, however, welcome to “like” our professional Facebook page @Gracecounselingoxford. We enjoy posting articles and information that we find helpful!

**HIPAA Notice of Privacy Practices**

*This notice describes how treatment information about you may be used and disclosed and how you can get access to this information should you so desire.* ***Please review carefully.***

By law we are required to insure that your Protected Health Information (PHI) is kept private. Your PHI includes information created and noted by us that can be used to identify you. This may include information about your past, present or future health needs and services. This may include information needed for payment of services should a third party insurance company be involved. Please note we reserve the right to change the terms of this Notice and our Privacy Policies at any time as permitted by law. Should we make any changes, we will provide copies of the new policies in print as well as on our website. You may also request a copy of this notice at any time.

Rights regarding your PHI: (1) You have rights to request limits on uses and disclosures of your PHI. (2) You have the right to amend your PHI (3) You have the right to get a list of disclosures we have made with your PHI. (4) You have the right to see and get copies of your PHI. (5) You have the right to receive a copy of this notice for your records.

Other Disclosure: Your consent to use PHI isn’t required if you need emergency treatment. (See Limits of Confidentiality) However, we will attempt to get your consent after treatment is rendered.

Complaints and Reporting Violations:

You may complain to the Secretary of the United States Department of Health and Human Services, 200 Independences Avenue S.W., Washington, D.C., 20201 and/or the Mississippi State Board of Examiners for Licensed Professional Counselors, 239 North Lamar Street, Suite 402, Jackson, MS 39201 if you believe your privacy rights have been violated under HIPAA.

My signature below indicates I voluntarily agree to participate in the assessment and counseling offered by *Grace Counseling Services PLLC* and practitioners*.* I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. By my signature below, I certify that I am not under a legal disability that prevents me from understanding the terms of this agreement and I accept all the terms and conditions as herein stated. I have read and understand the above notices regarding my PHI.

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

Client/Parent/Guardian Signature Date

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

Client/Parent/Guardian Signature (if needed) Date

***LIMITS OF CONFIDENTIALITY***

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records regarding a client cannot be shared without the written consent of the client or the client’s legal guardian. Exceptions are as follows:

Duty to Warn and Protect:

When a client discloses intentions to harm another person, the clinician is required to report this information to legal authorities and warn the potential victim if possible. In the case in which a client discloses suicidal ideations or plans, the clinician must make every effort to notify the family of the client or legal authorities.

Abuse of Children or Vulnerable Adults:

If a client states or suggests that he or she is abusing a child or a vulnerable adult, the clinician is required to report this to the Department of Human Services. If a client states they are being abused, neglected or exploited then the clinician is required to report this to the Department of Human Services and if necessary the legal authorities.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients (under 18) have the right to access the client’s records at all times.

I agree to the above limits of confidentiality and understand their meanings and

ramifications. I have received a copy of Notice of Privacy and Confidentiality for my records.

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

Client/Parent/Guardian Signature Date

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

Client/Parent/Guardian Signature (if needed) Date

**Compliance Contract**

**Cancellation Policy:**

Being engaged in your treatment is an important part of the process. If you fail to cancel a scheduled appointment, we cannot use this time for another client. Appointments must be cancelled **prior to 24 hours** of the session or you are subject to the entire session fees. Your credit card on file will be charged. *All account balances are due the day of service.*

Clients who do not appear within 15 minutes of their appointment time will forfeit the session for the day. This forfeited session is also billed to you as no other client was able to use the time either.

**Treatment Compliance:**

I understand the following:

 - It is my responsibility to update any changes to my billing information.

 - I understand records request could incur up to a $25 paper fee per request

 - I understand if my insurance does not cover the session fees set forth by Grace Counseling Service PLLC then I am responsible for the balance. My credit card on file will be used if I do not make other arrangements.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Our policy requires you place credit card information to keep on file for***

***payments and cancellation fees.***

Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date \_\_\_/\_\_\_\_

 CCV Code:\_\_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grace Counseling Services PLLC

2090 Old Taylor Road

Oxford, MS 38655

(662)307-7443

DIRECTIONS:

From Ole Miss campus:

Take Old Taylor Road to HWY 6 intersection with roundabouts. Continue down Old Taylor Road away from campus and take first RIGHT into University Office Complex.

After entering the parking lot follow the road to the RIGHT and up the hill. (You will pass by Kessinger Real Estate office on your right)

Our office is the first red brick building on the LEFT. The office faces Highway 6 and is located inside the Jackson Psychiatry Group. The sign for Jackson Psychiatry Group will be located beside the front door.

Inside the building the office is on the LEFT side, first floor. You will again see the sign for Jackson Psychiatry Group on the door.