Client Intake Form

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 10 minutes to complete.

Name:_____

Birth date: _____/_____/_____ Age:_____ Gender: Female

Marital status: Married

Number of children: _____ Ages: _____

Current address: _____
City _____ State _____Zip _____

Cell/Other: _____ May we leave a message? Yes

Email: _____ May we email/text you?* Yes

*NOTE: Email/Texts may not be confidential

Referred by:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes

Reason for change:_____

Have you had any mental health services in the past? Yes

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes

If yes, please list:_____

General Health and Mental Health Information

How is your physical health at the present time? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

_____

_____

Are you on any medication for physical/medical issues? Yes

If yes, please list:_____

Are you having any problems with your sleep habits? Yes If yes, select those that apply:

Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing dreams ☐ Other:_____

How many times per week do you exercise? _____ days _____ hours

Are there any changes or difficulties with your eating habits? Yes /es, select one:

Eating less ☐ Eating more ☐ Bingeing ☐ Restricting ☐

Have you experienced a weight change in the last two months? Yes

Do you consume alcohol regularly? Yes

In one month, how many times do you have four or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you felt depressed recently? Yes

If yes, for how long?_____

Have you had any suicidal thoughts recently? Yes

If yes, how often? ☐ Frequently ☐ Sometimes ☐ Rarely

Have you ever had suicidal thoughts in your past? Yes

If yes, how long ago?_____

How often did you have these thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely

Are you currently in a romantic relationship? Yes

If yes, how long have you been in this relationship? _____

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship?_____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

Quick Check

Select all of the issues that apply to you:

Memory Lapse ☐
Repetitive Thoughts ☐
Homicidal Thoughts ☐
Mood Swings ☐
Difficulty w/ Relationships ☐

Phobias ☐
Alcohol/Substance Abuse ☐
Anxiety ☐
Suicide Attempts ☐

Traumatic Event ☐
Sleep Distubances ☐
Body Complaints ☐
Trouble Planning ☐

Extreme Anxiety ☐
Hallucinations ☐
Eating Disorder ☐
Repetitive Behaviors ☐
Time Loss ☐

Are you currently employed? Yes

If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position?	Yes ☐	No ☐
Are you fulfilled in your current position?	Yes ☐	No ☐
Does your work make you stressed?	Yes ☐	No ☐

If yes, what are your work-related stressors?_____

Religious/Spiritual Information

Do you practice a religion? Yes

If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? Yes

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Anxiety Disorders ☐
Bipolar Disorder ☐
Panic Attacks ☐
Alcohol/Substance Abuse ☐
Eating Disorder ☐
Learning Disability ☐
Trauma History ☐
Domestic Violence ☐
Obesity ☐
Obsessive Compulsive Behavior ☐
Schizophrenia ☐
Depression ☐

Other Information

List your strengths _____

_____

List areas you feel you need to develop_____

_ _____

What do you like most about yourself? _____

_____

What are some ways you cope with life obstacles and stress?_____

_____

What are your goals for therapy/what would you like to accomplish? _____

_____

_____

Thank you for taking the time to complete the new patient intake form. – Tori Bowman, LPC-S, Therapist

Magnolia Roots Counseling

Tori Bowman LPC-S
115 Kohlers Crossing Ste. 115
Kyle, Texas 78640
(512) 202-0102 (PH)
(512) 842-7238 (FX)
www.magnoliarootscounseling.com

AGREEMENT FORM

Welcome to Magnolia Roots Counseling

Services:
The services provided include and are not limited to individual & couples counseling. Counseling services provided include and are not limited to Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, anxiety, depression, relationship issues and therapy for Trauma.

Magnolia Roots Counseling also provides transformational coaching which can enhance your mental health and overall wellness. It involves skill building for individuals and couples that are impacted by life changes that involve work, family, personal growth and success.

Private Pay Fees: Please contact me for private pay rates.
Fees for these services are due and payable at the time of your visit.

Sessions: What to expect....
The first session, "intake", consists of discussing your paperwork. This will provide an opportunity to do introductions and discuss what you are seeking from the counseling experience.

If Magnolia Roots Counseling cannot accommodate you or your needs, a referral will be provided. By signing this agreement you are authorizing the exchange of information between Magnolia Roots Counseling and any professional or agency to which you agree to be referred.

If you decide to continue, it is likely you will be provided short term counseling services. In that case, we will probably meet once a week for 50 minutes for a period of four to twelve weeks, depending on the outcome. In the event that you are in need of longer counseling services, you and I can discuss other options.

Process:
Counseling is a learning process and usually concerns itself with everyday problems and issues. The client and the counselor both have responsibilities. The counselor is responsible for listening in a caring manner, sharing her experience and education as they apply to the situation at hand, and helping construct outside activities, including assessments that might be helpful. The client is responsible for fully disclosing information about the issues being discussed and for completing outside activities that it is agreed will be helpful.
Counseling focuses on one concern at a time and multiple concerns can be prioritized. Both parties recognize that counseling is voluntary and confidential. Confidentiality will be broken, however, if the counselor is made aware of an intent to harm oneself or another, or in the case of abuse.

Emergencies:
In the event of an emergency please call 911. Also be aware that Seton Medical Center Hays is open 24 hours a day and can do an emergency assessment.

Cancellations:
If you need to cancel a scheduled appointment, please give 24 hours notice to avoid a **$75 cancellation charge**.

Appointments not cancelled with 24 hours notice, prevent others from scheduling.
All cancellations that are not within 24 hours are a $75.00. _____ *Initials*
Returned checks will incur an additional $30 charge to your next session. _____ ***Initials***

The counseling services you are utilizing at Magnolia Roots Counseling are not 24/7. All messages will be picked up and calls returned during regular business hours.

Email is not confidential and will not be utilized for counseling other than exchanging details about completing assessments online and confirming appointments.

Comments:
_____
_____

I have read both pages of this agreement and fully understand each section of this form and agree to participate in counseling services at Magnolia Roots Counseling under the provisions, guidelines, and limits delineated above.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

Magnolia Roots Counseling
Tori Bowman LPC-S
115 Kohlers Crossing Ste. 230
Kyle, Texas 78640
Phone: (512) 202-0102

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your Protected Health Information.

We are required by law to maintain the privacy of Protected Health Information and to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all Protected Health Information that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your Protected Health Information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose Protected Health Information to any other consultant only with your authorization.

For Payment. We may use or disclose Protected Health Information so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of Protected Health Information necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your Protected Health Information in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your Protected Health Information with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your Protected Health Information. For training or teaching purposes Protected Health Information will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your Protected Health Information to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect
Emergencies
National Security
Judicial and Administrative Proceedings
Law Enforcement
Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer Rolanda Bowman, LPC-S, at 115 Kohlers Crossing Ste. 230 Kyle, Texas 78640

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy Protected Health Information that may be used to make decisions about your care. Your right to inspect and copy Protected Health Information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the Protected Health Information we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your Protected Health Information. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your Protected Health Information for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of Protected Health Information to a health plan for purposes of carrying out payment or health care operations, and the Protected Health Information pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Rolanda Bowman, LPC-S, our Privacy Officer, at 115 Kohlers Crossing Ste. 230 Kyle, Texas 78640 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is _____.

I read this notice and was offered a copy of it_____