Rituals of Healing
PSYCHOLOGY GROUP

Confidential Client Intake Form

General Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Please only contact me at: ☐Home ☐Work ☐Cell E-mail:_____

Sex: ☐ M ☐ F Date of Birth:_____Age: _____ SS#:_____

Employer: _____ Occupation/Title:_____

Hours per week: _____ Years at job:_____Highest level of education completed: _____

Do you regularly attend church, synagogue or other religious institution? ☐Yes ☐No Pray/Meditate? ☐Yes ☐No

Do you identify as spiritual/religious…please specify religion or spiritual beliefs:_____

How did you hear about our services? :_____

Relational Information

Marital status: **0** Single **0** Engaged **0** Married **0** Separated **0** Divorced **0** Widowed

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____

For your current spouse? _____

Name of spouse:

_____

Spouse's age:

_____

Spouse's Occupation:

_____

Please provide a brief description of your spouse (e.g., angry, kind, controlling, outgoing, supportive): _

Please list your children, including step, adopted and foster children (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her or effect

Please identify any of the following you experienced in your family:

☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Abortions ☐ Gambling
☐ Addiction/Alcoholism ☐ Major Losses ☐ Divorce ☐ Incarcerated

Please describe the kind of family you grew up in: _

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in- patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse or mental health reasons? YES ☐ NO ☐

If yes, please describe: _____

Has anyone in your family ever attempted or committed suicide? YES ☐ NO ☐

If yes, who and when: _____

Medical History

Name and Town of Current Physician:

_____

Date and outcome of last physical exam:

_____

Please list any conditions, illnesses or surgeries:

_____

Please list current medications, even if not taken regularly (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues, Symptoms and Goals

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

If therapy ended today, how would your life be different? What do you hope to achieve?

_____

_____

Check any of the flowing current symptoms or problems you are experiencing or have recently experienced:

☐ Stress	☐ Grief	☐ Verbal abuse	☐ Impulsive behavior	☐ Anxiety
☐ Chronic pain	☐ Sexual abuse	☐ Controlling	☐ Sexual problems	☐ Fears
☐ Loneliness	☐ Hyper/Hypo Sexual	☐ Obsessive thoughts	☐ Depression	☐ Panic
☐ Indecisiveness	☐ Poor concentration	☐ Intrusive Thoughts	☐ No energy	☐ Anger
☐ Fatigue	☐ Low self-esteem	☐ Hearing voices	☐ Loss of appetite	☐ Bad dreams
☐ Marital problems	☐ Aggression/Anger	☐ Racing thoughts	☐ Trouble sleeping	☐ Apathy
☐ Relational issues	☐ Eating problems	☐ Physical Abuse	☐ Unwanted memories	☐ Alcohol use
☐ Feeling worthless	☐ Emotional Abuse	☐ Loss of control	☐ Pregnancy/Abortion	☐ Work issues
☐ Financial issues	☐ Spiritual apathy	☐ Drug use	☐ Career choices	☐ Loss
☐ Compulsive behavior	☐ Controlled by others		☐ Seeing/Hearing things others don't	

Do you drink alcohol daily? _____ How much? _____ Weekly? _____ How much? _____

Please place an "X" on the scale to indicate how distressing your problems are to you.

{----------} {----------} {----------}

Very minimal distress | Moderate distress | Very extreme distress

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Have you experienced suicidal thoughts or attempted suicide in the past? ☐ Yes ☐ No

Are you currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

_____ _____

Client's Signature | Date

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Informed Consent for Counseling Services

I am willingly entering into a counseling relationship with the understanding of the following conditions:

1) I understand that my counseling records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others) or I have signed the appropriate release of information forms.
2) Counseling will cover emotional, physical and spiritual aspects of my life and may sometimes be distressing and difficult. However, I understand working through my issues will enable me to achieve increase health both personally and relationally.
3) I have the right to ask questions pertaining to my treatment and may discontinue therapy at any time. I understand terminating counseling is best decided after consulting with my therapist.
4) I understand that *Rituals of Healing Psychology Group* does not accept insurance for partial or full payment of services rendered. I agree to pay $_____ at the conclusion of each appointment.
5) Barring emergencies, I understand I must cancel and/or reschedule my appointments by notifying the office **at least 24 hours** prior to the scheduled appointment hour. There will be a **charge** if appointment is cancelled within 24 hours of appointment time. If you do not call and do not show up for your appointment, the **full charge** will apply. In the evenings and on weekends, you may leave a message on our voice mail, which will accurately record the date and time of your call.

I have read and understood the preceding information and agree to the policies of Rituals of Healing Psychology Group as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through Rituals of Healing Psychology Group.

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date