Heart Healing Counseling Corporation
Deanne Carter, LMHC
www.hearthealing.org

Intake

Please return all 5 pages of your completed intake form
electronically, or by postal mail, to set up your first appointment.

Name: ____ **Today's date:** _______________
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ **Age:** ________ **Gender:** ☐Male ☐Female ☐Other (specify____________)

Marital Status: ☐Never Married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Address:____
(Street and Number) (City) (State) (Zip)

Home Phone: (   )_____________ **May I leave a msg?** ☐Yes ☐No

Other Phone: (   )_____________ **May I leave a msg?** ☐Yes ☐No This is my: Cell phone Work phone Pager

E-mail: May I email you? ☐Yes ☐No *Please be aware that email may not be confidential.**address**: ___________________________

Emergency Contact Name:____ Relationship:_____________

Address:____ Phone: _________________

Referred by: ☐Self ☐Friend ☐Family Member ☐Other__________
Are you here because you are choosing to be, or because you feel required to be? ☐Choice ☐Required

Where do you work? ___________________________ **Do you enjoy it?** Yes Somewhat No
Are you a student? Yes No

Are you currently or formally in the military? ☐Yes ☐No

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐Yes ☐No

Have you had previous psychological or counseling services? ☐Yes ☐No

Please read the Disclosure form:
This signed statement conveys that you understand the Health Care Provider Disclosure and Notice of Privacy Practices and gives consent to counseling sessions with Deanne Carter, LMHC. You may sign this at your first appointment.

________________________ ________________________ ____________
Client Name (print) Client Signature Date
I am 18 years or older.

LIFE FUNCTIONING INVENTORY

The information you provide will help in the planning of your counseling.
Please ask questions about any information you are uncomfortable with filling out.

Name: ____ Date: ____________________

CULTURAL BACKGROUND

1. What is your **ethnic identity**? ____

2. How much do you identify with your **ethnic heritage**? (Circle one):
   Not at all   A little   Somewhat   Moderately   Strongly

3. **Religious preference**:____
   Are your currently active in your religion?   Yes   Somewhat   No

FAMILY BACKGROUND

1. Please list the **members** of your family, including ages, note who you still live with:
   ____

2. Please check any past, present, or impending special problems you have experienced:

deaths	divorce	frequent relocations	debilitating injuries/disabilities
alcohol/drug abuse	serious illness	psychiatric disorder	emotional/physical/sexual abuse
legal problems	eating disorders	financial crisis/unemployment	attempted/completed suicide
neglect	Other: ____________________		

Please specify family member(s), which special problem (list above), and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

____

____

3. Have you personally experienced **family abuse**?
   None   Neglect   Emotional   Physical   Sexual   Unsure

4. Have you personally experienced **legal problems**?   No   Yes

5. Did you experience **learning problems** in elementary, middle, or high school? (Circle one):
   None   Little   Some   Substantial   Constant Struggle

6. In general, how **happy or adjusted** were you growing up? (Circle one):
   Poor   Unsatisfactory   About average   Substantially   Completely

7. How much is your immediate family a source of **emotional support** for you currently? (Circle one):
   None   Little   Somewhat   Substantial   Very Strong

8. How much **conflict in values** do you currently experience with your parents/immediate family? (Circle one):
   None   Little   Some   Moderate   Strong   Extreme

9. Who in your family do you currently **feel closest** to? ____________________
   Most **distant** from?____________________ In most **conflict** with? ____________________

10. Do you feel bad about yourself, or that you are a failure, or have let yourself or your family down?
    Not at all   Several days per week   More than half the time   Nearly every day

HEALTH AND SOCIAL ISSUES

Who is your **Primary Care Physician/Psychiatrist/ARNP?** ____

1. How is your **physical health** at present?   Poor   Unsatisfactory   Satisfactory   Good   Very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, Diabetes, etc.):____

3. Are you **presently** taking any **prescribed medication**? If Yes: Name/Dosage________________________________
For what purpose: ____________________________Who is prescribing? ______________________________________

If No: Have you **previously** been prescribed psychiatric medication? ☐Yes ☐No If yes, how long have you been off? ______

4. Are you having any problems with your **sleep habits**? No Yes (If yes, circle below)
Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Feel tired frequently Other

5. Are you having any difficulty with **appetite or eating habits**? No Yes (If yes, circle below)
Eating less Eating more Binging Restricting Significant weight change (last 2 months)

6. Do you worry about your **weight** or how you look? Not bothered Bothered a little Bothered a lot

7. Do you regularly use **alcohol**? Yes No
In a typical month, how often do you have 4 or more drinks in a 24 hour period? __________
Do you consider your alcohol consumption a problem? Yes No Unsure

8. How often do you engage **recreational drug use**? Daily Weekly Monthly Rarely Never
Do you consider this drug use a problem? Yes No Unsure

9. Do you have any problems or worries about **sexual functioning**? No Yes (If yes, circle below)
Lack of desire Performance problem Sexual impulsiveness Difficulties maintaining arousal
Little or no pleasure during sex Worried about sexually transmitted disease Other

10. How many times per week do you **exercise**? __________ For about how long each time? ___________

11. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?
Frequently A few times Once Never Unsure If so, how old were you? ____________

12. Have you had **suicidal thoughts** recently? Frequently Sometimes Rarely Never
Have you had them in the past? Frequently Sometimes Rarely Never

13. Have you ever intentionally **inflicted any harm upon yourself**? Yes No Unsure

14. In the past, how would you rate the quality of your **peer relationships**?
Very Poor Unsatisfactory About Average Good Excellent

15. In the last 6 months, how would you rate the quality of your **peer relationships**?
Very Poor Unsatisfactory About Average Good Excellent

16. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? ________ Are you in one now? Yes No I think so

17. Besides family members, who can you really count on right now for **friendship or emotional support**?
____

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish relief from right now.

____

____

2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in?
(Circle the appropriate number): Not Intense 1 2 3 4 5 Extremely Intense

3. PROBLEM DURATION: Approximately **how long** have you had the current problem? ______________________

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?
____

5. SELF-SOOTHING: What strategies do you have that are calming/quieting/soothing to you?

Calm place mediation___ Healing Light Stream through your body ___ Squeeze/Release Muscles___
Deep Breathing ___ Put worries in a Container/Box ___ Family/Friends/People Support ___
Body Scan ___ (thoughts, emotions, body sensations)
Other: ____

Thank you for taking the time to carefully consider these questions. Our work together is a collaboration and it is helpful to have the above information to better understand your life experiences, and current situation.

***Option 1:* If you would like me to submit your insurance claim for reimbursement, or you have First Choice, * complete all of the information below (even if it is also on page 1). I will need to photocopy your card and ID during your first appointment. Please provide a copy of the insurance card prior to the first appointment-if the card holder will not be present.**

____
Insurance Company Name Insured's ID Number Group Number Plan Name

(___)___-____
Eligibility/Provider/Behavioral Health Phone Number Policy Holder's Name * Policy Holder's Address *
(please do not leave blank-this number is on the back of your card)

____
Policy Holder's Telephone * Policy Holder's Date of Birth * Policy Holder's Employer *

____
Patient's Name- if different than policy holder Patient's Address- if different than policy holder

____
Patient's Telephone- if different than policy holder Patient's Date of Birth- if different than policy holder

Patient Status: Single Married Is the patient employed? Yes No Is the patient a student? No Part time Full time

It is my understanding that this release of information to my insurance company can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.

I understand that Heart Healing Counseling Corporation will submit my claim to my insurance as a courtesy and I am responsible for paying my balance due at the time of each session.

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of signature. Please include all of the requested information above. You may sign your completed form at your first appointment.

____ ________________
Signature (client / parent / guardian / legal representative for healthcare decisions) Date

***Option 2:* Self Pay Agreement**
(It is to your advantage to disclose if your Behavioral Health benefits are First Choice Health.)

I attest that I :

a.) do not have insurance coverage, or
b.) have insurance coverage but choose not to use it,
and understand that in doing so I waive my right to reimbursement, or
c.) have insurance coverage, but understand this is not a covered service.

The fee I have negotiated is: $155 Intake ________ 55 min _______ 75 min
You may sign this at your first appointment.

I understand the Self Pay Agreement. ______________________ ______________________ ______________
Signature Printed Name Date

Required for Option 1 or 2 above: Debit/Credit Card Authorization Form (next page)

To set and hold your appointments, please complete the attached Debit/Credit Card Authorization form below.

You may call in credit/debit info, if you are not comfortable providing it electronically.

Heart Healing Counseling Corporation
Deanne Carter, LMHC
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253.651.3752

Debit/Credit Card Authorization Form

I, ____________________________, hereby authorize Deanne Carter, LMHC, NCC and ProfessionalCharges.com to charge my credit card as listed below for the following professional fees:

- appointments that I elect to pay by credit card.
- missed or cancelled with less than 24 hours notice

Usual professional fee: $ 155 Intake Appointment
$____ per 55 min $____ per 75 min

Complete all information below, even if you have provided it elsewhere on the intake. Thank you.

Client Name: ____
Print First Middle Initial Last

Name on card (if different): ____
Print First Middle Initial Last

Relationship to card holder (other than self): parent grandparent spouse son/daughter

Card Holder's Billing Address: (the address on file associated with this card)

____
Street Number/PO Box Street City State ZIP

Billing Phone: ( ) ____-_____

Type of Card: VISA ☐ MasterCard ☐ Discover ☐

Card Number: ______ ______ ______ ______

Expiration Date: ______ / ______
Month Year

CVV #: ______ (the three digits on the back of the card)

Email for receipt: ____(I will not receive a copy of your receipt, please save them if you need for your documentation)

Card Holder's Signature ____________________________________ Date: ____ / ____ / ____

You may sign your completed form at your first appointment.

*Charges will appear on your card statement as **ProfessionalCharges.com***

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