

COUNSELING AND THERAPY INTAKE FORM

Practice: [practice name]

Clinician: [name, license type and number]

Address / phone / email: [practice contact details]

Please complete this form before your first session. Skip any question you'd rather talk about in person.

1. About You

Full name: [client's full legal name]

Name you'd like us to use: [name]

Pronouns (optional): [pronouns]

Date of birth: [date]

Address: [street, city, state, ZIP]

How may we contact you? (check all that are okay)

☐ Mobile phone: [number] ☐ Okay to leave a detailed voicemail ☐ Okay to text

☐ Home phone: [number] ☐ Okay to leave a detailed voicemail

☐ Email: [address] ☐ Okay to email about scheduling and billing

2. Emergency Contacts

Contact 1: [name], [relationship], [phone]

Contact 2: [name], [relationship], [phone]

☐ I give permission for my clinician to contact the people above if my clinician believes I am in an emergency.

3. What Brings You In

In your own words, what would you like help with? [answer]

How long has this been going on? [answer]

What would you like to be different after therapy? [answer]

4. History

Have you been in counseling or therapy before? ☐ No ☐ Yes: [when, with whom, how it went]

Have you ever been hospitalized for mental health reasons? ☐ No ☐ Yes: [when]

Current medications (name and dose): [list, or "None"]

Prescribing provider: [name and phone, or "None"]

Primary care provider: [name and phone]

Any medical conditions we should know about? [list, or "None"]

Alcohol use: ☐ None ☐ Occasional ☐ Weekly ☐ Daily

Drug or other substance use: ☐ None ☐ Yes: [describe]

In the past few weeks, have you noticed any of the following? ☐ Low mood ☐ Anxiety or worry ☐ Trouble sleeping ☐ Changes in appetite ☐ Trouble concentrating ☐ Relationship stress ☐ Grief or loss ☐ Work or school stress ☐ Other: [describe]

Safety. Are you currently having thoughts of harming yourself or someone else? ☐ No ☐ Yes

If you are in immediate danger, call or text 988 (Suicide and Crisis Lifeline) or 911, or go to the nearest emergency room. Do not wait for your appointment.

5. Consent to Treatment

I understand that:

- Therapy involves talking about personal matters. It can help, and it can also bring up uncomfortable feelings for a while.
- My clinician will explain the approach they recommend, and I can ask questions about it at any time.
- I can stop therapy at any time.
- Sessions last about [number] minutes.
- ☐ I have received and read the practice's full informed consent document.

6. Confidentiality and Its Limits

What I say in therapy is kept confidential, and my clinician will not share it without my written permission, except in situations like these:

- My clinician believes disclosure is necessary to prevent or lessen a serious and imminent threat to my safety or someone else's.
- My clinician suspects abuse or neglect of a child, and in some cases of an elder or dependent adult, and state law requires a report.
- A court orders the release of records.
- Other situations required or allowed by the law of [State]: [describe, e.g. duty to warn an identified person]

My clinician will try to talk with me first when that is possible and safe.

If the client is a minor: the parent or guardian's access to session information will follow [State] law and this agreement: [describe what will and won't be shared].

7. Telehealth (complete only if sessions may be by video or phone)

☐ I agree to receive services by telehealth.

Platform: [name of video platform or "phone"]

During sessions I will be in a private place in the State of [State], and I will tell my clinician if I am in a different location.

My address during sessions (for emergencies): [address]

Backup phone number: [number]

If the connection drops, my clinician will ☐ call me at the backup number ☐ send a new link.

I understand that telehealth has some privacy and technology risks, and that my clinician may recommend in-person care if telehealth isn't a good fit.

8. Fees and Policies

Session fee: [\$ amount] for [number] minutes.

Payment is due: [at each session / other].

☐ The practice will bill my insurance: [carrier and member ID]. I am responsible for any amount insurance does not pay.

☐ I am paying privately.

Cancellations: I will give at least [number] hours' notice. Late cancellations and missed sessions may be charged [\$ amount].

Between-session contact: [how the clinician handles calls, texts and emails, and typical response time].

9. Notice of Privacy Practices

☐ I acknowledge that I received a copy of this practice's Notice of Privacy Practices.

10. Accuracy and Electronic Signature

The information I've given is accurate to the best of my knowledge. I will tell my clinician about important changes.

I agree this form may be signed electronically, and an electronic signature has the same effect as a handwritten one.

Signatures

Client

Signature: _____

Name: [full name]

Date: [date]

Parent or Guardian (if client is a minor)

Signature: _____

Name: [full name]

Date: [date]