Life Essentials Health Center

Confidential Client Intake Form

GENERAL INFORMATION

Last Name _____ First _____ Middle Initial ____

Preferred Name _____ Birth Date ____/____/____ Male ___ Female ___

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____ Other (____)_____

Any phone instructions (re: msgs, etc) _____

Email #1 _____ Email #2 _____

Emergency Contact _____ Phone (____)_____

Relationship _____

Parent/Guardian (if under 18) _____

Referred by/How you learned of us.: _____

Reason for referral _____

Religious/Denominational preference: _____

Your church/synagogue _____ Member? _____

Pastor/Priest/Rabbi _____

Attendance: Regular ___ Occasional ____ Seldom ____ Never ____

FAMILY INFORMATION

Relationships: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Cohabiting ___

Parents: *Mother:* Living ___, age ____. Deceased ___. *Father*: Living ___, age ____. Deceased ___

Siblings: Number of *Brothers* [ ]. Number of *Sisters* [ ]. Only Child ____.

Names and ages of *your* children: _____

_____

_____ Have any of your children died? _____

Household members not listed above _____

_____

EMPLOYMENT/EDUCATION INFORMATION

Full time employee ____ Full time at home ____ Part-time employee ____ Unemployed ____

Place of employment _____ Length of Employment _____

Type of work you do _____

Highest level of education completed: High School ___ College degree ___ Graduate degree ____

Professional Training ____ Other _____

What concerns/life issues could be limiting you today?_____

_____

_____

Check the following words that describe you at this time:

____ Anger	____ Loneliness	____ Self-esteem
____ Anxiety	____ Loss of faith in God	____ Sexual Problems
____ Chronic fear	____ Loss of hope	____ Stress
____ Conflicts at work	____ Loss of meaning in life	____ Substance abuse
____ Depression	____ Loss of work/job	____ Suicidal feelings
____ Financial Problems	____ Marriage problems	____ Religious doubts
____ Grief	____ Nervousness	____ Other (list)
____ Guilt feelings	____ Rage	_____
____ Health Issues	____ Relationship to parents	_____
____ Irrational fears	____ Relationship to children	_____

What are you hoping to achieve with counseling sessions?

_____

_____

_____

_____

MEDICAL/PSYCHOLOGICAL HISTORY

Name of your physician:_____Phone: (____)_____

When was your last medical examination? _____

Are you suffering any physical illnesses or symptoms at this time? _____

List major surgeries or illnesses in the last five years: _____

_____

List current medications: _____

_____

_____

Are there chemical abuse issues in your family? Yes ___ No ___ If clean/sober, for what length of time? _____

When? _____ Name of helping agency: _____

Have you received psychotherapy or counseling in the past year? Yes ___ No ___ When? _____

Name of treating therapist: _____ Where? _____

Type of problem: _____

_____

Make a check mark if you would answer “yes” to any of these questions:

___ Do you have thoughts of harming yourself or others?

___ Are thoughts of harming yourself or others a frequent occurrence?

___ Do you dwell on these thoughts and wonder if you can control them?

___ Have you sought professional help because of these thoughts or feelings?

_____ _____

Client’s Signature Date

_____ _____

Counselor’s Signature Date

**Courtesy of Marie Carter*

Life Essentials Health Center Counseling

Consent for Treatment

Thank you for choosing **Life Essentials Health Center**. Below you will find information that helps you understand the counseling process. If you have any questions about this information, please ask your counselor/therapist.

Contact Information:
Mailing address:
Life Essentials Health Center **Phone (843) 284.8410**
1501 Hwy 17 N Suite H
Mt Pleasant, SC 29464

Confidentiality:
The information you share in counseling is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed by a judge only). Therapists/counselors are mandated by state and federal regulations to breach confidentiality when:

1. a client is threatening suicide or self-harm.
2. a client is threatening homicide or harm to another person.
3. there is suspicion of child abuse or neglect.
4. there is suspicion of elder abuse or neglect.
5. a client has broken or intends to break a law(s).
6. a client requests the health information to be released to someone, signing a Release of Information Form.

All records are kept under lock and key. We are not able to identify our clients without their authorization.

Fees:
Your counselor will talk with you about the fee during the first session. It is customary to pay the fee at the beginning of each session. You may be charged for a telephone session lasting longer than 15 minutes. **Life Essentials Health Center** does not file insurance claims for our counseling clients. There is a $30 fee for returned checks. Sessions will be 45 minutes, with 10 minutes allotted for documentation.

Reminders:
You may be called or text for a reminder appointment unless you specify otherwise. Please note Life Essentials serves as a health center, and other staff and or patients may be present in the office during your session. We will strive to maintain a quite and private setting whenever possible.

Cancellation Policy:
You understand that you are responsible to keep your counseling appointments, and that you are to notify the counselor at least 24 hours in advance of any appointments which cannot be kept. If you provide less than 24 hours notice, your account will be charged for the regular rate of your usual appointment.

Emergencies:
The counselors of **Life Essentials Health Center** are not available 24 hours a day. If you anticipate emergencies may arise, work out a plan with your counselor. Otherwise, you may want to call your pastor, doctor, family member, or go to the nearest hospital emergency room. The 24 hour Hotline number is 1-800-922-2283.

Informed Consent:
Your signature on this document verifies you have been given this Consent for Treatment Form, your counselor/therapist's Professional Disclosure Statement, and the HIPPA document. Signing indicates that you have read and understood this information, as well as giving your consent to counseling/therapy. Here are further items for your information:

1. Counseling/Therapy is not always successful, and may open unexpected emotionally sensitive areas.

2. Your counselor/therapist is not a medical doctor and cannot prescribe medications.
3. Your counselor/therapist may need to consult with other professionals on your case for supervision purposes. He/she will keep your identity in the strictest confidence in this process.
4. Nina Class is a licensed through:

   The South Carolina Board of Examiners for Counselors
   PO Box 11329
   Columbia, SC 29211-1329
   (803) 896-4652

_____

Client Signature, Date

_____

Counselor Signature, Date