Emily Yi, LCSW
Clinical Counseling from a Christian Perspective

NEW CLIENT INTAKE FORM

Full Name: _____ Date: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Social Security Number: _____

Email: _____

Party Responsible For Payment: (if different from above)

Full Name: _____ Date: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Social Security Number: _____

Email: _____

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ADULT INTAKE FORM

Chief Concern

Please describe the main difficulty that has brought you to see me:

Your medical care (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When

From Whom:

For What:

Results:

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List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Not Applicable

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

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CLINICIAN PATIENT AGREEMENT

By signing this form, you are giving permission for us to treat your child under 18 years of age.

Rights and Risks:

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.

Appointments:

- All office visits are by appointment and may be scheduled through your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.

_____	_____
Signature of Client (Required for Youth 13+)	Date
_____	_____
Signature of Legal Guardian	Date
_____	_____
Signature of Clinician	Date=

Emergencies:

The **best phone number** during business hours is 904-357-0536. If you receive the voice mail, please leave a message with your name and phone number. In a crisis situation, please call 911 ***or*** **go immediately to your local hospital emergency room.**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Parkwood Counseling Center to

☐ **Obtain** ☐ **Release** ☐**Exchange**

the following written verbal electronic video audio information (check all that apply):

☐ Treatment plan ☐ Social History ☐ Psychiatric Evaluation
☐ Discharge Summary ☐ Psychological evaluation and test results
☐ Behavioral Observation ☐ Physical Exam ☐ Medical treatment
☐ Alcohol/drug treatment ☐ Other: _____

Information from the records of:

_____ To/From:_____
Client Name Agency Name

_____ _____
Address Address

_____ _____
(City, State, Zip) (City, State, Zip)

_____
Date of Birth

For the purpose of: ☐ to assist in the evaluation and treatment of the client
☐ Other (specify)

To Receiving Agency: PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read this authorization and fully understand its contents.

_____ _____
Signature of Client (Required for Youth 13+) Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Relationship Telephone Number

_____ _____
Witness Date

This release shall be valid for
☐ a single disclosure
☐A continuing disclosure for 90 days
☐A continuing disclosure for 1 year

TO BE SIGNED TO REVOKE RELEASE OR TO INDICATE A REFUSAL TO SIGN:

Refusal to sign or revocation of this release in writing at any time is not a condition of treatment, payment, enrollment or eligibility for benefits.

_____ _____

Signature of guardian or youth over 18 years of age Date

THERAPY FEES

Services	Licensed Mental Health Professional
Intake (45-50 min)	$150
Individual, couple, or family session	$150
Short session (25-30 min)	$80
School Observation & Recommendations	$150/Hr
No Show Fee	Full price of session

*Fees are as of March 1, 2023 and are adjusted periodically

No Show Fee: A canceled appointment delays our work. When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a canceled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, you will be charged the full fee for your session unless I am able to fill it with another client. The only time I will waive this fee is in the event of serious or contagious illness or emergency.

FINANCIAL AGREEMENT

By signing below I agree to the above fee schedule and understand payment (cash or check) is due in full at the beginning of each counseling session.

I understand the following regarding use of insurance:

If I have insurance coverage, Parkwood Counseling Center is considered Out of Network. I can

- Bill my insurance using an approved diagnostic code (in which case I would be responsible for the difference between what my insurance covers and the full amount listed above)
- Decide not to use my insurance and pay in cash to the full amount listed above

If I do not have insurance coverage I will pay the fee listed above in full.

Client: _____ Date: _____

Parent/guardian: _____ Date: _____

Clinician: _____ Date: _____