6135 King Road, Suite D, Loomis, CA 95650
Phone: 916-676-7405 Fax: 916-471-0559
www.heartstringscounseling.org

New Minor Client Intake Form

Todays Date______________ Referred By:__________________

Minor's Name ______________________ Date of Birth ______________________

Street Address ______________________ City ______________ Zip ___________

School ______________________ Grade _________ Family Gross Income ______________

Parent(s)/Guardian(s) Name(s) ______________________ Cell Phone _____________ Home Phone _____________

Work Phone _____________ Email Address ______________________

Emergency Contact (Besides Guardian/Parents) ______________________ Relationship to Minor ______________________

Address ______________________ Phone ______________________

Adults With Whom Minor Lives With:

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Siblings:

Name ______________________ Age ______________________

Name ______________________ Age ______________________

Name ______________________ Age ______________________

Medical History:

Previous Counseling? ☐ Yes ☐ No

Have you taken, or are you now taking, any prescription medications for mental health issues

☐ Yes ☐ No

What prescriptions?____

For how long?____

Prescribed by whom and for what conditions?______________________________

Please give a brief summary of the **specific reason** you are seeking counseling at this time. Be assured this information is confidential and will be used only for the purpose of assigning you to the appropriate counselor.

____
____
____
____
____
____

I give permission to Heartstrings Counseling to send me emails, announcements and updates regarding additional services and products related to mental health.

☐ Yes ☐ No

I would like biblical principles incorporated into my counseling sessions.

☐ Yes ☐ No ☐ I don't know

I would like to request a handicap accessible room and I cannot walk upstairs.

☐ Yes ☐ No

Choose your payment option below:

☐ **I am ABLE to pay the reduced clinical counseling fee of $85.**

☐ **I am UNABLE to pay the above fee and wish to use for the SLIDING FEE SCALE (based on my monthly income).**

☐ **I would like to be referred to a licensed Marriage and Family Therapist for $135/(one hour)session for individual, couples, families and/or EMDR .**

Print Name ______________________________

Signature______________________________**Date** ____________

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Consent to Treat a Minor

The undersigned is the responsible parent or legal guardian and hereby authorizes Heartstrings Counseling and its staff to provide counseling to the minor stated below. Also, the parent or legal guardian understands that while a therapy session is a 50 minute long hour, some young children benefit from shorter sessions. In either case, the parent or legal guardian recognizes that the transportation to and from, and the supervision of the children before and after session are the sole responsibility of the parent or guardian.

____ ____________________

Name of Minor   Date

____ ____________________

Signature of Parent or Legal Guardian   Date

____ ____________________

Signature of Parent or Legal Guardian   Date

Information for Client

Confidentiality

What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to suspected child abuse, elder abuse, dependent abuse, threatened homicide or suicide.

HIPAA & Confidentiality

Most counselors are willing to maintain contact with you via text, email, or other electronic means. Although we cannot be certain that this information will not be intercepted, we will do our part to protect your confidentiality.

____ **Please initial here** if you understand the risks of communicating with your counselor by electronic means, and still wish to do so. Your initials indicate you understand the risk, and consent to electronic communication with your counselor.

Counselors

Counseling is provided by counselors who are in training to become Licensed Marriage and Family Therapists (LMFT). They are supervised weekly by a licensed therapist. During these supervision meetings, your information may be discussed between counselors and with the supervisor and Executive Director in an effort to gain understanding and build skill and knowledge related to marriage and family therapy. Counselors, at times may request to record your session for the purpose of training and education. However, we value your confidentiality and will make every effort to only share unidentifiable information. Please check here to indicate whether you will allow your therapist to record your therapy session ___Yes ___No

Counseling Services

Heartstrings Counseling is a safe environment open to all members of the community. We strive to encourage positive change and personal growth that will brace and sustain the heart. Furthermore, we provide each client with the option of integrating Biblical principals into the treatment plan. As a client of Heartstrings Counseling you are not required to bring these principles into session; however, you may if interested.
Please check here to indicate if you would you like Biblical principles to be included in your counseling sessions? □ Yes □ No □ I Don't Know
* Please note that you can change this selection, verbally or in writing, at any time.

Fees and Payment
Your fee is based on a sliding fee scale according to your average monthly income and ability to pay. Payment of fees will be due at each session. Cash, check, and credit cards are accepted. There is a $15 fee for any returned checks. The only form of insurance that is accepted at Heartstrings Counseling is the state Victims of Crime Compensation Program. However, if for some reason the program does not pay for the services provided, each client will be responsible for the payments.

Cancellations
Cancellations must be made 24 hours in advance. If an appointment is canceled or missed without 24 hours of notice, you will be charged your usual fee for that missed session.

Your Session
Your therapy session is a 50 minute hour.

Your Counseling Experience
Counseling is a unique and highly individualized experience. It is an opportunity to learn about yourself, your relationships, and the world around you. Most people seeking counseling are hoping for improvement in at least one area of their life and this is definitely possible through dedication and consistent counseling sessions. Although you may want immediate relief, it is common for symptoms to get worse before they get better. Remember that it may have taken time for your struggles to develop, and it may also take time for you to begin to feel better.

Counseling involves change, which may feel threatening, not only to you, but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel very vulnerable. At the same time, counseling can aid you in discovering tools and techniques, which can be utilized to improve the quality of your life and relationships. As the person involved in this process, you have the right to ask your counselor questions about his/her professional experience, background and theoretical orientation.

Please ask for any clarification needed for the above

______________________________ ________________

Client Signature Date

______________________________ ________________

Client Signature Date

______________________________ ________________

Counselor Signature Date

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Symptom & Problem List

Please check all that you have experienced in the last 90 days

___No energy	___Mood Swings	___Overly Confident	___Racing Heart
___Cannot Enjoy Life	___Unusual Experiences	___Distractible	___Stomach Problems
___Memory Problems	___Physical Numbness	___Sexual Indiscretion	___Sleeping too much
___Anxiety	___Panic Attacks	___Socially Withdraw	___ Always on Guard
___Fatigue	___Vomiting	___Eating Disorder	___ Apathetic
___Anger Outbursts	___Impaired Vision	___Alcohol Use	___Numbing Out
___Shortness of Breath	___Back Pain	___Seeing things	___Distrustful
___Sweating	___Drug Use	___Excess Energy	___Buying Sprees
___Hot flashes	___Insomnia	___Unsure of Reality	___High Risk Activities
___Reliving Past Events	___Disturbing Memories	___Wishing to Die	___Family Arguments
___No Loving Feelings	___Low Self-Esteem	___Confusion	___Often Physically ill
___Fears	___Poor Appetite	___Weight Change	___Hearing Voices
___Chest Pains	___Headaches	___Impaired Hearing	__Losing Track of Time
___Decisions Difficult	___Nightmares	___Muscle Spasms	___Slowed Thinking
___Racing Thoughts	___Heart Palpitations	___Tremors	___Physical Violence
___Clammy Hands	___Depressed	___Unsure of Identity	___Easily Startled
___Hard To Make Friends	__Guilt Feelings	___Seizures	___Work Problems
___Flashbacks	___Poor Concentration	___Sporadic Dieting	___Hopeless Feelings
___Overeating	___Blackouts/Fainting	___Sexual Difficulty	___Dizziness
___Suicidal Thoughts	___Unwanted Thoughts	___Hypertension	___Hallucinations
___Taking Pain Killers Often	___Out of Control Behavior		

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Credit Card Agreement

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the counselor at your initial session.

CC Type: MC   Visa   Amex   Other_______________

Name as shown on card____

CC Number____

CC Expiration Date______________________________

3-digit security code on back of the card________________________

Billing Zip Code associated with the card________________________

This card may be charged for:
__X__ Regular session fees (at your request, as a convenience to you)

__X__ Fees for cancellation without_24__hours notice (according to a counselor's policy)

__X__ Delinquent session fees (fees more than 30 days overdue)

"I __________________________________ (print name) have read and understand the terms of providing my credit card to Heartstrings Counseling. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered.

_______________________________________ (signature) __________________(date)