Minor Counseling Intake Form

Please fill out this form to help me know more about the concerns and to ensure counseling sessions focus on what is most important. Information provided is confidential as outlined in the Professional Disclosure Statement. HIPPA Notice of Privacy is posted online at pillarsofhopecounseling.com. Happy to answer any questions about either document.

Name_____Date_____

Address _____City/ State_____ Zip_____

Contact # _____Alternative # _____

OK to leave messages at these phone numbers? ☐ Yes ☐ No OK to text these numbers? ☐ Yes ☐ No
*Please note email and/or texting is not considered confidential communication.

Email_____

Date & Place of Birth _____Age_____ Gender: ☐ F ☐ M

Your current marital status: ☐Never Married ☐Married ☐Partnered ☐Separated ☐Widowed ☐Divorced
List past and present significant relationships _____

_____

List family and friends you count on for support_____

_____

Currently attending school? ☐ Yes ☐ No Please check all degrees earned from the list below.

☐ High School Diploma or ☐ GED Year _____

☐ Associates Degree Year _____ Area of study_____

☐ Undergraduate Degree Year _____ Area of study_____

☐ Master Degree Year _____ Area of study _____

☐ PhD Degree Year _____ Area of study _____

Current Employer _____Position_____Length of Service _____

Do you find your work enjoyable? ☐ Yes ☐ No Are finances a major stressor? ☐ Yes ☐ No

Military History: ☐N/A ☐Current ☐Discharged (If currently serving or discharged) Rank_____

Branch _____ Date of Discharge _____ Were you in combat? ☐ Yes ☐ No

Are you involved in any current or pending civil or criminal litigation/s, lawsuits, divorce proceedings, or custody disputes?
☐ Yes ☐ No (If "yes" please explain) _____

_____

Emergency contact person_____ Phone # _____

Referral source or how you came here: _____

Have you experienced any of the following medical conditions during your lifetime?

☐Abortion	☐Allergies	☐Asthma	☐Chronic Pain	☐Diabetes
☐Dizziness	☐Fainting	☐Headaches	☐Head Injury	☐Hearing Problems

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☐High Fevers ☐Meningitis ☐Miscarriages ☐Seizures ☐Serious Accident

☐Sleep Disorders ☐Stomach Aches ☐Surgery ☐Vision Problems ☐Other

List any additional health concerns _____ Date of last physical _____

List current medications:

Medication	Dosage	Start Date

Describe any past or present drug/ alcohol use/abuse or treatments. _____

_____

Describe any suicide attempts or violent behavior._____

_____

Please check *all* that apply:

☐Abuse ☐Abandonment ☐Adjustment concerns ☐Appetite or eating issues

☐Anger ☐Anxiety or worry ☐Career concerns ☐Communication

☐Depression ☐Divorce ☐Downsizing /Layoff ☐Emotional Abuse

☐Fears or Phobias ☐Financial Abuse ☐Grief or Loss ☐Image concerns

☐Infidelity ☐Intimate Partner Violence ☐Isolation ☐Loneliness

☐Marital Unrest ☐Mood Swings ☐Nervousness ☐Obsessions or compulsions

☐Posttraumatic Stress ☐Recurring Thoughts ☐Relationship concerns ☐Role Adjustment concerns

☐Self-Esteem ☐Sexual Abuse ☐Sleep concerns ☐Social Anxiety

☐Spiritual concerns ☐Substance Abuse ☐Suicidal Thoughts ☐Trauma

Have you received counseling before? ☐ Yes ☐ No (If "yes" please provide the reason and with whom) _____

_____

Have you been previously diagnosed with a mental disorder? ☐ Yes ☐ No (If "yes" please explain) _____

_____

What do you wish to accomplish in counseling? _____

_____

How long has this been troubling you? _____ Please indicate severity: ☐Mild ☐Moderate ☐Serious

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Consent for Counseling Services Office Policies & General Information Agreement for Therapy Sessions

Name_____

I request Angelie Karabatsos provide professional counseling and talk therapy.

I understand that Mental Health Services of Professional Counseling (talk therapy) is provided to me/us at a cost of $80.00-$95.00 per session.

I agree payment of services is due at the time of services, even if I am seeking reimbursement from my insurance company. I understand there is no guarantee of coverage or reimbursement for fees.

I understand it is my responsibility to contact my therapist, 24-48 hours in advance, if I am unable to keep my appointment time to avoid paying full charges for missed appointments or no-show appointments.

I understand that my therapist will not be available for 24-hour crisis intervention or emergencies and I have been informed where to call if I have any emergency; Washington County Crisis Line (503) 291-9111, the National Suicide Prevention Line (800) 273-8255, or 911.

I recognize that parents or legal guardians of non-emancipated minors have the right access files and information.

I acknowledge that I have received a copy of Angelie Karabatsos' Professional Disclosure Statement and have been directed to pillarsofhopecounseling.com for a copy of HIPPA Notice of Privacy Practices. I will review these documents and understand I may discuss questions with my therapist anytime during my treatment.

I understand that email, text, and social media are not confidential forms of communication. I give permission to be contacted by the following forms of communication: Phone ☐ Email ☐ Text ☐
I may request a change at any time by submitting a written request of change to Angelie Karabatsos.

I understand too many late cancels and/or non-payment for late cancel/no show appointment may result in termination.

If there has been no appointments within 90-days the relationship will be terminated. Clients may resume counseling at anytime.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above with the understanding that my therapist and I will clarify goals and objectives at any time.

X_____ _____

Signature of Parent (Guardian) Date