Group Intake Form

Type of Group: _____Middle School _____High School _____Adult (Anxiety/Depression)

Information about client (participant):

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Social Security Number: ___________________________

Age: ________ **Gender:** __________ Grade: __________ School: ___________________

Address: ____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) **May we leave a message?** □ Yes □ No

Cell/Other Phone: ( ) **May we leave a message?** □ Yes □ No

E-mail: ____ **May we email you?** □ Yes □ No

Information about parent/guardian

____
(Last) (First) (Middle Initial)

Address: ____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) **May we leave a message?** □ Yes □ No

Cell/Other Phone: ( ) **May we leave a message?** □ Yes □ No

E-mail: ____ **May we email you?** □ Yes □ No

Topics you would like addressed in group

_____COVID-19 _____Social Justice _____ Schooling from Home _____Family Dynamics

Primary Physician: ________________________**Phone Number:** _______________________

FAMILY/SOCIAL HISTORY

Where were you Born/raised: ____

- Siblings: # of brothers __________ #of sisters __________
- What was the birth order? __________ of __________children
- Who primarily raised you? ____

Do you have a social network or support? (friends, activities, church, groups, etc.…)

____

____

GENERAL HEALTH INFORMATION:

Are you currently taking any prescription medication (including psychiatric meds)?

□ Yes
□ No

Please list: ____

____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: ______________

____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

Please list any difficulties you experience with your appetite or eating patterns

____

MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ Yes, previous therapist/practitioner: ____
□ No

Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes
If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? ____________________________________

What do you consider to be some of your strengths?

____

What do you consider to be some of your weakness?

____

What would you like to accomplish out of your time in therapy?

____

____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date

Consent for Treatment for Middle School and High School Groups

It is our goal to make your experience here an informed and positive one. Please review and complete the following information. If you have any questions, please feel free to discuss them with us.

Financial Responsibilities

Middles School and High School Groups will be **FREE OF CHARGE** during the Coronavirus Pandemic. Parents and Guardians are not responsible for any fees at this time. __________**Client Initials**

Training and Clinical Supervision

- SMR Counseling Services is a training center for Master's and Doctoral level Counseling, Social Work, and Psychology interns. All counselors at SMR Counseling Services are under the supervision of licensed mental health professionals.
- In order to ensure that counselors receive the best possible training, and that clients are well served, some sessions will be video, or audio taped. Tapes are viewed by SMR Counseling Services clinical supervisors only and are erased in a timely manner. You must agree to be taped to receive counseling services at SMR Counseling Services.
- Counselors are generally on a time limited contract with SMR Counseling Services; Therefore, it is possible that your counselor may leave SMR Counseling Services prior to the end of your therapy. If this occurs, we will take reasonable steps to ensure a smooth transition. __________**Client Initials**

Cancellations and Missed Appointments

Even though group sessions will be **free**, we require 24-hour notice for cancellations and reschedules so that your appointment time could be available for another client in need. If client misses more than two sessions, they will be removed from the group so that other people in need can participate. __________**Client Initials**

End of Treatment

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you. __________**Client Initials.**

SMR Counseling Services reserves the right to discontinue counseling at any time including, if we do not believe you will make progress on your mental health condition because of no-shows or late cancellations. We may consider you an inactive client with us if: (1) Sixty (60) days have passed, (2) You do not have any scheduled appointments with us, and (3) We have not heard from you. You will receive a letter stating that your file has become in-active. You may contact us to set up an appointment to become active again. Although we make an effort to remind you about upcoming appointments by text message and email, you are responsible for remembering and attending your appointments. __________**Client Initials.**

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to SMR Counseling Services to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

I, _________________________agree to all the terms and conditions of this contract.
Printed name of client or representative

____

Client Signature (Client's Parent/Guardian if under 18) **Today's Date**