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# CONSULTATION INTAKE FORM

*Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide is held to the same standards of confidentiality as our therapy.*

**Name:** _____
(Last) (First) (MI)

**Parent/Legal Guardians:** _____

**Birth Date:** ____ /____ /____ **Age:** _____ **Gender:** □ Male □ Female □

**Address:** _____

_____
(City) (State) (Zip)

**Marital Status:**
□Never Married □Partnered □Married □Separated □Divorced □Widowed

**Spouse:** _____
(Last) (First) (Middle Initial)

**Children's Names and Ages:** _____ _____

_____ _____

**Primary Phone:** ( ) - Emergency Phone: ( ) -

**Voicemail?** □ Yes □ No **Text?** □ Yes □ No Emergency Person: _____

E-mail: _____ **Please be aware that email might not be confidential.*

## OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes Employer: _____

Job Title: _____ Length at current Job: _____

## HEALTH & SOCIAL INFORMATION

1. How is your physical health at present? □Poor □ Fair □ OK □ Good □Excellent
2. How regularly do you use alcohol? □ Daily □ Weekly □Monthly □Rarely □Never
3. Do you engage recreational drug use? □Daily □ Weekly □Monthly □Rarely □Never

4. Are you currently in a romantic relationship? □ No □ Yes how long? _____

Quality of your relationship: □Poor□ Fair □ OK □ Good □Excellent

5. Is there anything in your relationship you would like to mention that may require special consideration or sensitivity from your coach? (i.e. LGBTQ, Gender Identity, Sexual Trauma, Religious Trauma/Purity Culture, Sexual Behaviors or non-traditional relationship parameters such as polyamory, open marriage, etc.) _____

_____

_____

## CURRENT MEDICATIONS:

| Name: | Dose: | Treatment of: | Prescriber: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Additional Notes:** _____

_____

_____

## GOAL SETTING:

☆What do you consider to be your personal strengths?

☆What are some effective self-care strategies you have learned? (exercise, journaling, etc..)

☆What are your goals for this coaching/consultation?

Please use this space to provide any other necessary information you would like to share.

_____

_____

_____

## SOCIAL MEDIA CLAUSE

Per practice policy, use of social media by way of Facebook, Instagram, Twitter, and other outlets, for coaches and their clientele to connect is prohibited for a minimum of 2 years post the termination of the coaching relationship and is then up to the coach's discretion. This serves to protect the integrity of the relationship.

## LIMITS OF CONFIDENTIALITY

All information disclosed within consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the customer presents an imminent danger to self,
3. When the customer presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

## INFORMED CONSENT

I, _____, **(client)** hereby consent to treatment by way of coaching or consulting with _____**(coach)** on this date & beyond. I understand that all efforts made by this coach to assist in the meeting the goals set forth by the client and will be given with the best or intentions and out of the best interest of myself and all others involved in the process. If at any time I feel that services are not meeting my expectations, or I require more specific care, (such as a licensed mental health counselor in your state) I can request a referral to an alternative provider that might better meet my goals without any bias or discrimination.

I recognize that a copy of the **HIPAA Privacy Policies** for care has been made available online with the printable paperwork for me to print and keep for my own records.

I realize that 1) **Online Coaching** includes consultation or coaching through emails, telephone conversations, and other online mediums to exchange medical information using interactive audio, video, or data communications.
2) The laws that protect the confidentiality of a client's medical records and information also apply to online coaching. Unless a release of information has been provided to discuss treatment with a 3rd party, the exchange is confidential. I, as a coach, will not include others in the session or have others in the room unless agreed upon.
3) By signing below, you acknowledge that online coaching does not provide emergency services. If you are experiencing an emergency situation, you understand that you can call 911 or proceed to the nearest hospital emergency room for help.
4) As with traditional coaching, there are risks to consider, including, but not limited to the following possibilities, despite reasonable efforts on the part of the coach: the transmission of information could be disrupted or distorted by technical failures; the transmission of information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Each person is responsible for information security on their computer.

_____ _____
Client/Guardian Signature (if client is under 16) Date

## FINANCIAL AGREEMENT:

***This practice is committed to providing you with the best possible care. In order to achieve these goals, we need your assistance & your understanding of our payment policy.***

Payment for service is due at the time services are rendered *unless* payment arrangements have been agreed upon *in advance*. We accept most credit cards, cash, check and Venmo, though a small fee may be charged with credit transactions. Please note that any returned checks will have a service charge of $25 per check to cover the counselor's bank fees.

## SESSION ATTENDANCE:

It is important to understand that a session missed is also a session that cannot be booked for other customers, and time away from the coach's home life. Your appointment time cannot be filled with other clientele *unless the appropriate notice has been given*. For this reason, we ask that you make every effort to provide at least a **24-hour advance notice** by your coach's provided best contact (email/call/text).

We understand that crisis situations occur and circumstance can conflict with your ability to keep your appointment, and your coach will consider the circumstances carefully. In most situations, when the appropriate amount of time has not been given to cancel, you may anticipate that **the full fee** will be applied to the card you choose to keep on file.

*This measure has been created out of necessity to ensure a mutual respect is established for one another's time.*

**This practice requires that ALL clients provide a valid credit/debit card to keep on file to assist in preventing missed sessions that are unable to be filled by other clients.**

**My Identified session fee is: _____/coaching hour (50-60 minutes)**

Credit/Debit Card to keep on file for phone sessions, payment use, and potential no shows is:

Card #_____ Expiration: _____ CVV#: _____

Card billing zip code: _____Name on the card: _____

Preferred Email address/cell number for receipt: _____

***By signing below, I recognize that I have read and understand this coach's expectation for the service I will receive s as well as for my financial commitment to my care. I am acknowledging and consenting to receive virtual care with a coach and NOT mental health counseling or receiving any form of a medical diagnosis. Should this coach/consultant find that I need more support for my care, a referral will be made to no less than 3 qualified providers in my area and termination of services may occur per my best needs.***

*Signed:* _____*Date:* _____

*Coach's Signature:*_____*Date:* _____
Rebekah Bragan, MMFT *under the supervision of Joanna Dixon, LMFT #1070*