CLIENT INTAKE & CONSENT FORM
JEMESE LACHEL PSYCHOTHERAPY & COACHING, LLC
JEMESE LACHEL EDMONSON, MSW, LCSW

Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Today's Date: ___/___/___
Name of Person completing this form (if other than client):
_____
Your relationship to client_____

PERSONAL INFORMATION

Client's Name_____ Date of Birth: ___/___/___ Sex: M___ F___
Marital Status: Single___ Married___
Guardian's Name_____ Relationship_____
Physical Address: _____
_____ _____ _____
City State Zip Code
Mailing Address: _____
(if different from _____ _____ _____
above) City State Zip Code

Client Phone: Home _____ Cell _____ Other _____
May we text at your cell phone number? ____
Name of School or Employer _____ Phone# _____

May we leave a message at these numbers? Yes / No Limits _____
E-Mail Address_____

Emergency Contact Information
1. Name & Relation to Client: _____ Phone:_____

2. Name & Relation to Client: _____ Phone:_____

Referral Source: _____

INSURANCE INFORMATION

Primary Insurance: (Circle) Tricare BCBS Medicare Other
If Other, Name of Insurance: _____
Client's Insurance Number: _____
Name of Insured: _____ Insured Date of Birth: __/__/_____
Address of Insured: _____
Relationship to Insured (if other than self): _____
Insured's Employer: _____
Secondary Insurance (if applicable) _____

NAME: CLIENT _____

PRESENTING PROBLEMS: (Circle as appropriate to current situation)

DANGER TO SELF: None. Thoughts of suicide/ selfharm. Threats of suicide. Preoccupation with death. Suicide gesture. Suicide attempts. Family history of suicide.
Other_____

DANGER TO OTHERS: None. Thoughts to harm others. Threats of harm to others. Plans to harm others. Felt like killing someone. Attempts to harm others. Has harmed others.
Other_____

RELATIONSHIP PROBLEMS: None. Trouble bonding Conflicts with peers, siblings, parents, spouse, children, significant other, No/few friends. Running away from home. Separation, divorce. Family abandonment. Visitation or custody disputes. Child abuse. Spouse abuse. Child neglect.
If abuse, specify_____
Death in family. No significant relationships.
Other_____

History of trauma/abuse/violence in family:
_____

History of mental health issues in family:_____

BIOLOGICAL FUNCTIONS: Sleep (no change, increased, decreased, restless), Appetite (no change, increased, decreased), Weight (no change, loss, gain). Sex (no change, increased, decreased). Concentration (short term, long term) Other_____

History of major physical illness in family: _____

SUBSTANCE ABUSE:	None. Has abused in past: Narcotics, amphetamines, hallucinogens, inhalants, Marijuana, alcohol, cocaine, prescription drugs_____ Other_____ Current abuse: Narcotics, amphetamines, hallucinogens, inhalants, Marijuana, alcohol, cocaine, prescription drugs_____ Other_____ . How long:_____, amount _____ D. T's, black-outs. Intoxicated now. Hospitalization(s). Family problems. Absenteeism. Job Loss. Abuse related arrests. Other _____ History of family substance abuse: _____
DEPRESSIVE-LIKE Feelings of BEHAVIOR: Anger.	None. Sadness. Fatigue. Hypoactive. Loss of interest. worthlessness. Guilt feelings. Crying. Other _____
ANXIETY-LIKE	None. Anxiety. Numbness, blindness, paralysis or any physical symptom with no biological cause please describe:_____. Obsessions. Compulsions. Phobia (s). Panic Attacks. Exaggerated Startle Response. Body sensations complaints:_____. Bedwetting. Nightmares. Other _____.
LEGAL/BEHAVIORAL PROBLEMS	None. Frequent lying. Stealing. Excessive fighting. Destroys property. Fire setting. Arrests. Convictions. Imprisoned. Impulse control. Probation. Parole. Pending charge. Other _____.
EMPLOYMENT	Good. Jobs held briefly (less than 2 years).Frequently fired Retired.
BEHAVIOR/ SATISFACTION	Unemployed. On disability. Laid off. Seeking disability. Other_____. Satisfaction level:_____. Occupation Needs/Goals_____.
FINANCIAL PROBLEMS: Bankrupt.	None. Financial stress. Debt-ridden. Reckless spending.

HOUSING PROBLEMS: None. Dilapidated. Overcrowding. Must Move. Homeless. Inappropriate cohabitants.

EDUCATIONAL HISTORY: None. Behavior problems. Peer, social, academic (reading, math, Other _____). Education level ____
Successes/Struggles:_____
Special Services/Assessments:_____

ANGER: High level of anger. Anger Outbursts. Other:_____

SELF CONCEPT: Low Self-Esteem. Grandiose Self Concept.

RELIGIOUS HISTORY: None. Active/Inactive (explain): _____

What is (are) the Problem(s) that Bring You into Therapy at This Time?

_____
_____
_____
_____
_____

How severe are your problem(s)? Mild Moderate Severe

When did they begin? _____
Was there a time when it/they got better? _____
Was there a time when it/they got worse? _____
How often you do experience it/them? _____

What do you consider to be some of your strengths?
_____
_____
_____
What do you consider to be some of your weaknesses?
_____
_____
What would you like to accomplish out of your time in therapy?
_____
_____
Tentative Diagnosis (Office Only): _____

ALL PERSONS LIVING IN HOUSEHOLD WITH CLIENT

NAME	AGE	RELATIONSHIP TO CLIENT

PHYSICIAN INFORMATION

Name of Primary Physician: _____
Address of Doctor's Office: _____
Phone Number: (___) _____ Fax Number: (___)_____
Last Physical Exam Date: _____

MEDICAL INFORMATION

MEDICAL PROBLEMS Past and Present:

_____
_____
_____

PRESCRIBED MEDICATIONS:

MEDICATION	DOSAGE / FREQUENCY	START DATE	ANY SIDE EFFECTS?

PRIOR THERAPISTS	LENGTH OF TREATMENT	DATE OF LAST CONTACT

I consent for Jemese LaChel Edmonson, MSW, LCSW/ Jemese LaChel Psychotherapy and Coaching,LLC. to provide psychotherapy for myself, my child and /or family. I understand that all information shared will be confidential with the exception of a suspicion of harm to self, others or child abuse/ neglect. I also understand that information gathered will be for purposes of treatment only and not for court purposes or disability determination unless otherwise noted in the treatment plan. Such services will incur additional fess.

I give permission for my primary care physician and insurance company to be contacted for the purpose of obtaining benefit information, visit authorizations, and submitting insurance claims. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to provider for services provided. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I agree to make all payments or co-payments at the time of services. I agree to give 24 hours notice to cancel a scheduled appointment. If notice is not given at least 24 hours in advance, I will be required to pay the full cost of the session.

I have read these guidelines and have a clear understanding of them. I agree to participate in the therapeutic process on these terms and conditions.

_____	_____
Signature of Patient/Client	Date
_____	_____
Therapist	Date

CLIENT CONSENT & AUTHORIZATIONS
JEMESE LACHEL PSYCHOTHERAPY AND COACHING, LLC
JEMESE LACHEL EDMONSON, MSW, LCSW

Authorization for Contact by Telephone/Verbally in Event of Breach of PHI

I, _____(name of patient/client), authorize Jemese LaChel Psychotherapy & Coaching, LLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Jemese LaChel Psychotherapy & Coaching, LLC. Such conversation shall be documented by Jemese LaChel Psychotherapy & Coaching, LLC.
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Jemese LaChel Psychotherapy & Coaching, LLC.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

Notice of Privacy Practices Receipt and Acknowledgment of Notice

I, _____(patient/client name) hereby acknowledge that I have received and have been given an opportunity to read a copy of Jemese LaChel Psychotheray & Coaching's/Jemese Edmonson's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jemese Edmonson, MSw, LCSW at 573-427-2992.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

Authorization for Electronic Communication

I _____(patient/client name), agree that Jemese LaChel Psychotherapy & Coaching, LLC./Jemese LaChel Edmonson, MSW, LCSW may communicate with me electronically unless and until I revoke this authorization by submitting notice to Jemese LaChel Psychotherapy & Coaching, LLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.

☐ Patient/Client Refuses to Acknowledge Receipt

TREATMENT PLAN
JEMESE LACHEL PSYCHOTHERAPY & COACHING, LLC
JEMESE LACHEL EDMONSON, MSW, LCSW

Client's name: _____DOB: _____ Date _____

Presenting problem: _____

Therapist: _____

Axis I:

Problems/Symptoms Goals/Objectives Treatment Strategies

I have discussed the information listed above, various treatment strategies, and their possible outcomes. I have received and/or read my copy of my rights as a client and procedures for reporting grievances. I concur with the above diagnosis and treatment plan.

Client's signature: _____ Date:_____

Guardian's signature: _____ Date: _____

Therapist's signature: _____ Date_____