HeartLINK
CHRISTIAN COUNSELING, PLLC

Counseling Intake Form

Each person attending therapy should complete a separate form.

Full Name: _____

Nickname: _____ Gender: ☐Male ☐Female D.O.B.: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

May we leave a message on your home phone? □Yes □No

May we leave a message and/or text on your cell phone? □Yes □No

May we leave a message on your work phone? □Yes □No

Best Phone for us to Contact you: ☐Cell ☐Home ☐Work

E-mail: _____ Is it okay to contact you via email? ☐Yes ☐No

Referral Source/How did you hear about this counseling practice? _____

May we contact them to thank them for the referral when applicable? ☐Yes ☐No

If yes, please provide their contact information: _____

Emergency Contact: _____

Relationship to Client: _____ Phone _____

My Current Overview:

The major concern(s) that led me to seek help: _____

_____

_____

My problem / symptom(s) began: _____(date). My symptom(s) increased: _____(date).

My three biggest worries/concerns in life now are: 1. _____

2. _____ 3. _____

Any medical problems / Surgeries: _____

_____

Current Medications and dosage (include psychiatric, sleep, over-the-counter, vitamins and supplements):

_____

_____

_____

_____

Name of Primary Physician: _____

Date of last lab work: _____ Results: _____ Health: ☐Excellent ☐Good ☐Fair ☐Poor

Name of Psychiatrist (if applicable): _____

Current Symptoms (check all that apply):

- ☐ Increased Crying
- ☐ Sad Mood
- ☐ Lack of Motivation
- ☐ Sleep Pattern (More) or (Less)
- ☐ Appetite Changes ↑ or ↓
- ☐ Weight Changes ↑ or ↓
- ☐ Lack of Interest
- ☐ Decreased Self Esteem
- ☐ Hopeless / Helpless Feeling
- ☐ Energy Level ↑ or ↓
- ☐ Chest Discomfort
- ☐ Abdominal (Stomach) Distress
- ☐ Feeling Dizzy
- ☐ Fear of Going Crazy
- ☐ Startled Response
- ☐ Chills or Hot Flashes
- ☐ Outburst of Anger
- ☐ Anxiety in General
- ☐ Panic Attacks
- ☐ Restlessness, Keyed Up, Fatigued, Decreased Concentration, Irritability, Muscle Tension, Decreased Sleep
- ☐ Hypervigilance - excessive attention & focus on internal and external stimuli
- ☐ Obsessions / Compulsions- Ex: constant checking, washing, or counting type behaviors; unrelenting worries
- ☐ Avoidance of stimuli associated with trauma
- ☐ Agoraphobia - anxiety of places or inescapable situations
- ☐ Social Anxiety - marked & persistent fear of social or performance situations where embarrassment may occur
- ☐ Phobia (specify): _____
- ☐ Post-Traumatic Stress
- ☐ Intense Fear
- ☐ Flashbacks
- ☐ Rapid Heart Beat
- ☐ Increased Sweating
- ☐ Trembling
- ☐ Shortness of Breath
- ☐ Withdrawn
- ☐ Nightmares
- ☐ Inattention
- ☐ Hyperactivity
- ☐ Delusions/Paranoia
- ☐ Hallucinations (hearing voices-music that no one else hears, seeing things no one else sees)
- ☐ High with Racing Thoughts, Increased Speech, Decreased Sleep, and Increased Activity
- ☐ Impulsive
- ☐ Isolating self from all contact with others
- ☐ Memory impaired with trouble organizing & sequencing
- ☐ Amnesia / Lose Time
- ☐ Somatization - undue health worries with adequate medical explanation
- ☐ Agitated - Irritable (easily annoyed provoked to anger)
- ☐ Chronic Pain (specify): _____
- ☐ Alcohol Abuse: # of drinks in the last week: _____
- ☐ Substance Abuse: _____ _____
- ☐ Drugs you've used: _____ _____
- ☐ Behavioral Problems: _____ _____
- ☐ Developmental Problems: _____
- ☐ Self-Mutilation: _____ _____
- ☐ Legal Issue(s): _____ _____
- ☐ Sexual Issue(s): _____ _____
- ☐ Eating Issue(s): _____ _____
- ☐ Grief / Loss: _____ _____
- ☐ Other: _____ _____

SUICIDE IS A DEFINITE POSSIBILITY NOW

☐Yes ☐No

My History:

Have you had similar problems/symptoms in the past? ☐Yes ☐No. If yes, when: _____

Did they recently increase? ☐Yes ☐No. What caused the increase? _____

Name 3 past stressful events in your life that precipitated the original symptom(s): _____

_____

My Birth and Early Development was: ☐Normal ☐Abnormal. If abnormal, explain: _____

_____

My childhood was overall: ☐Painful ☐Uneventful ☐Good

I have a history of: ☐Abuse ☐School Problems ☐Abandonment ☐Relationship Problems ☐Disability ☐Job Problems ☐Legal Problems ☐Other: _____

My Family of Origin to Present:

Father - What was he like? _____

Mother - What was she like? _____

Brothers / Sisters - how many of each? _____

Where did you fit in the birth order? _____

What type of relationship did you have with your siblings? _____

Marriages - How many? _____ What types of stress in marriage? _____

Children - How many? _____ Ages and sex of each? _____

School History: ☐High School ☐GED ☐Vocational or Trade School ☐Some College

☐College Graduate - Where / Degree(s): _____

Job History: _____ Current Job: _____

Religious History (past to present): _____

Counseling / Psychiatric History:

Prior Outpatient Counseling: ☐Yes ☐No. Therapist: _____ Date(s): _____

Prior Psychiatric medications: ☐Yes ☐No. Specify meds: _____

_____ Prescribing Doctor: _____ Date(s): _____

Prior Psychiatric Hospitalization? ☐Yes ☐No. Where: _____ Date(s): _____

Substance Abuse History? ☐Yes ☐No. When began? _____ Substances: _____

Any treatment? ☐Yes ☐No. Facility: _____ Date(s): _____

Past & Current History Summary:

I grew up in _____(state). I grew up in the ☐country ☐a small town ☐a large city. Both parents ☐were ☐were not in the home. My childhood was ☐good ☐difficult ☐very difficult in the sense of _____. My teen years were ☐good ☐difficult ☐very difficult in the sense of _____. In high school my life revolved around ☐sports, ☐work, ☐church, ☐social, ☐academics, ☐other: _____. After high school, life has been ☐good ☐difficult ☐very difficult in the sense of _____. I am currently ☐single ☐married for ____ years. I presently live ☐alone ☐with my spouse ☐with my parents ☐other (specify): _____. My current support system is ☐good ☐fair ☐poor. Life now centers around ☐family ☐work ☐friends ☐other: _____. Recently life has been ☐good ☐difficult ☐very difficult in the sense of _____. Genetic factors ☐do not ☐do seem to contribute in that relative(s) of mine (specify):_____ _____ had _____. My spiritual life ☐has ☐has not been a factor in the sense of _____.

Self Rating Report of Symptoms

Rate each symptom in the list below using the following 0 to 10 scale.

0 - - - - - - - - - - - - 1 - 5 -10

Almost Never	Present a small amount of the time	Present most of the time, to a significant degree	As Severe As Possible

Symptom	Rating	Additional Info
Depression	_____	Sad, down feeling
Anxiety	_____	Nervous, tense, apprehension
Insomnia	_____	Circle all that Apply: Difficulty falling asleep, difficulty staying asleep, early morning awakenings
Low Energy	_____	Tired, fatigued
Anger	_____	Irritable, angry, frustrated
Low Motivation	_____	Low initiative, low interests
Manic	_____	Overly high, overly energetic, poor judgement, rapid thinking
Inattention	_____	Trouble paying attention, distractible, forgetful
Behavior Problems	_____	Specify: _____
Hyperactivity	_____	Hyperactive, fidget
OCD	_____	Obsessions / Compulsions / Repetitive, irrational worry or actions
Trouble Functioning	_____	Circle all that apply: at work, socially, other:_____
Dysthymia	_____	Sad mood most days for last 2 years - ☐Yes ☐No
Stressed	_____	List Stressors (including recent changes): _____ _____
Worry	_____	Worry most days for the last 6 months - ☐Yes ☐No
Pain	_____	Specify: _____
Mood Swings	_____	Drastic changes in mood
Decreased Cognition	_____	Difficulty thinking, decreased ability to retain or learn information
Auditory Hallucinations	_____	Hearing things that are not there
Visual Hallucinations	_____	Seeing things that are not there
Paranoia	_____	Increased suspicion or exaggerated distrust of others
Nightmares	_____	

I certify the information provided in this Counseling Intake Form is correct to the best of my knowledge.

Signature _____ Date: _____

HeartLINK
CHRISTIAN COUNSELING, PLLC

Client Agreement / Informed Consent

Welcome to HeartLink Christian Counseling!
Whether you need brief supportive therapy or have wounds from the past that are impacting you today, it is our goal to be a safe place for you. We work with our clients in a collaborative way to achieve their goals. Hope often emerges when we invite God and safe people into the mess. We look forward to joining you on the journey in a way that creates space for hope, healing and connection.

Overview of Services
We offer counseling services for individual adults, couples and families. Counseling and psychotherapy both refer to a supportive relationship with a professional practitioner who has undergone extensive training and personal exploration to understand the dynamics of human experience and psychological development. At HeartLink, not only do we have extensive psychological training, we are also Christ followers. We work collaboratively with you in reliance on God for a treatment plan that considers your spiritual, psychological, biological and social dimensions.

Experience and Education
Stacey W. Farmer is a Licensed Professional Counselor with a master's degree in counseling from Dallas Theological Seminary. She worked with Dr. Frank Minirth for over 16 years at the Minirth Clinic as a counselor. She deeply enjoys and has extensive experience helping clients with depression, anxiety, trauma, abuse, obsessions, loss, anger, sense of self, relationships and spiritual issues. She is also passionate about coming alongside people who have wounds from the past that are affecting present day living. Because of this she pursued training in two other areas. First, she received a Doctor of Ministry in Formational Counseling in 2009. Next, she became certified in EMDR therapy in 2017.

Therapy
Effective therapy requires a partnership of mutual respect between the therapist and client. We will work together to determine what makes the most sense at this juncture in your life. Progress depends on a number of factors including the therapeutic alliance and the client's availability to work toward goals in between sessions. Benefits of therapy include finding a fresh perspective or resolution to a difficult problem; developing skills for improving relationships; learning new ways to navigate stress, anxiety, anger or depression; working through trauma or loss; having a safe context to process and release wounds; growing in connection with self, God and others; and living in increasing health, hope and freedom.

Certain discomforts and tensions associated with the counseling process should be understood before work begins. These include but are not limited to the following: 1) Recalling unpleasant events can surface feelings of fear, anger, sadness and other strong emotions that may be uncomfortable but are a normal part of the healing process. 2) Significant relationships may experience varying degrees of tension. 3) Sometimes problems temporarily worsen at the beginning of treatment. Most of these are to be expected when someone is making significant changes. It is impossible to guarantee specific therapy results; however, it is our goal to work with you to achieve the best possible results for you.

Confidentiality
Psychotherapy, counseling, assessment and associated services that are related to the diagnosis, evaluation and treatment provided by licensed professionals are confidential and protected under Texas state law. All communications and records with your counselor are held in strict confidence, with the following exceptions: 1) The client signs a written release indicating consent to release records or share information regarding treatment; 2) the client is at risk of imminent serious harm to self or someone else; 3) mandated reporting of any known abuse, neglect or exploitation of a minor, elderly person or disabled person; 4) a court order is received directing the disclosure of information; and 5) as outlined in the HIPAA Notice of Privacy Practice.

Electronic Communication
Confidentiality cannot be guaranteed with electronic communications, including telephone calls, voice mails, texts, emails and faxes. These electronic modes may be used for scheduling and other communications. If you would prefer not to be contacted by a certain method of communication, please note this on the Counseling Intake Form and we will honor your request. Should you want to make changes to your preferred method of communication you can let your counselor know at any time.

Therapeutic Relationship
The client-therapist relationship is a professional collaboration. Over the course of treatment, therapy can be psychologically intense and emotional. For an effective therapeutic environment, it is a necessary requirement that we maintain a professional relationship and not a social one.

Counseling Sessions/Fees
Generally, counseling sessions are 45-50 minutes on a weekly basis for a fee of $125 per session. Session frequency, length and fee may vary depending on the client's specific needs. A client can request a 90-minute session ($225 per session) when scheduling an appointment. Additionally, EMDR therapy sometimes requires an extended session; if so, this will be discussed in advance with the client.

Payment is due at the time of service. We provide a billing receipt so you can file your claim for insurance reimbursement when applicable. We accept cash, check, HSA, Visa, MasterCard, American Express, and Discover. A service charge of $35 will be charged for each check returned to HeartLink Christian Counseling. After receiving a returned check, we will only accept cash or credit card payments.

Scheduling and Cancellation
If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. Sessions must be cancelled with at least **a 24-hour notice to avoid the full session fee.**

Litigation Fees
If your therapist's involvement is required for litigation, the fee is $300 an hour. This includes time spent in photocopying, preparation, travel time, deposition and courtroom appearances. A $900 retainer fee for all court and legal-related services is due at least 48 business hours before the scheduled appearance.

Referrals
A client has the right to withdraw from our agreed-upon treatment process at any time and request a referral for any reason. It is recommended that you schedule a termination session for reaching closure. Counselors reserve the right to withdraw from the treatment process if your needs are outside our scope of knowledge and expertise or if we determine that we are no longer able to be helpful to you. In the event we initiate withdrawal from your treatment, we will provide you with appropriate referrals, which you are free to accept or decline. Referrals may also be made in conjunction with therapy; for example, a referral for a medical evaluation while you continue with therapy.

Grievance/Complaint
You can expect our counseling services to be in a professional manner consistent with acceptable ethical standards. If you have any issues, concerns or questions regarding any aspect of your experience you are invited to talk it over with your therapist so accommodations can be made. However, if you believe that we or any other counselor have treated you unethically or caused you harm, you may submit your grievance in writing and/or inform the Texas State Board of Examiners of Professional Counselors, 1100 W. 49th Street, Austin, Texas 78756, Phone: 512-834-6658 or Fax: 512-834-6789.

In Case of an Emergency
Please be aware that we **do not provide 24-hour emergency services**. If you experience a life-threatening emergency, please contact 911 or go to the nearest hospital emergency room. If you are suicidal and therefore at risk of imminent harm to yourself, help is also available by contacting the following: **24-hour Suicide and Crisis hotline at 214-828-1000 or 866-672-5100.**

Client Agreement
I agree to pay the counseling fee at time of service and for cancellations with less than a 24-hour notice.

I agree to receive mental health assessment and authorize treatment and other services as considered advisable and as detailed in this Client Agreement/Informed Consent form. I agree to participate in the planning of my care as well as in the treatment plan.

I have read, understand, agree and consent to the conditions of service stated in this agreement. If at any time I require additional clarification or review, I agree to request information from HeartLink Christian Counseling, PLLC.

_____

Printed Name

_____ _____

Signature of Client **Date**

HeartLINK
CHRISTIAN COUNSELING, PLLC
1475 Richardson Drive, Suite 230
Richardson, TX 75080

HIPAA COMPLIANCE AGREEMENT

I hereby acknowledge that I have been offered a copy of HeartLink Christian Counseling's Notice of Privacy Practices (NPP), which explains how my protected health information may be used and disclosed. I have read and understand this document and have been given the opportunity to ask questions and clarify my rights as a client.

Client's Name (Printed): _____ Date: _____

Client's Signature: _____

Stacey Farmer, MA, DMin, LPC
HeartLink Christian Counseling
1475 Richardson Dr., Suite 230
Richardson, TX 75080
972-454-0123

CONSENT FOR TECHNOLOGY / TELEHEALTH CONSULTATION

Technology / Telehealth consultation incorporates counseling or therapy services held via a video conferencing application. You will be provided the link for the technology / telehealth consultation. Please use the link five minutes before our scheduled session the first time. Please ensure you are in a private location where you can speak openly without being overheard or interrupted by others. If possible, it is recommended you wear a headset or earbuds for confidentiality and sound quality.

Please know that per best practices and ethical guidelines I can only practice in the state I am licensed, which is Texas. You agree to inform me if your therapy location changes, or if you move out of the state of Texas.

If we lose connection during our telehealth session, and we are unable to reconnect via the video conferencing link, I will call you immediately using the phone number provided in your intake paperwork. Please let me know if your phone number changes.

If I have concerns about your safety at any time during a telehealth (video or phone) session, I will need to break confidentiality and call 911, the emergency services in your area and/or your emergency contact immediately. Please note that everything in the informed consent that you signed, including confidentiality exceptions, still applies during telehealth sessions.

By signing this document, I as the client acknowledge:

1. I understand that this form is in addition to the regular Client Agreement / Informed Consent Form and Notice of Privacy Practices for Protected Health information commonly known as HIPAA.
2. I understand that telehealth consultations are not the same as in-person consultations due to the fact that I will not be in the same room as my provider.
3. I understand that telehealth consultations have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
5. I understand that my provider and telehealth consultations are NOT Emergency Services, and in the event of an emergency I will use a phone to call 911.
6. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

7. I have had the opportunity to ask questions in regard to telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____Signature _____Date

_____Printed Name