Wilson Counseling
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# PERMISSIONS AND CONSENTS

See **FOR YOUR RECORDS** form for corresponding information

**Client Name: _____**

1. **ASSIGNMENT OF BENEFITS** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

2. **PRACTICE POLICIES AGREEMENT** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

3. **PERMISSION TO TREAT FOR MYSELF** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

4. **CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION** (All clients MUST sign)

_____ _____
Signature of Client or Guardian Date

5. **SESSION RECORDING POLICY** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

6. **CLIENT TEXTING/EMAIL CONSENT** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

7. **PERMISSION TO TREAT FOR MY CHILD. IF JOINT CUSTODY BOTH PARENTS MUST SIGN!**

_____ _____
Signature of Parent 1 Date

_____ _____
Signature of Parent 2 Date

8. **PERMISSION TO TREAT VIA TELEHEALTH** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

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# INTAKE PACKET

**NEW** ☐ **UPDATED** ☐ **THERAPIST:** _____

Client Name: _____ Today's Date: _____

Responsible Party (if different) & Relationship: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ or _____ SSN: _____

Date of Birth: _____ _____ Age Gender: ☐ Male ☐ Female ☐ Other

Emergency contact/Relationship and phone number: _____

Health Insurance Provider: _____

Who referred you to Wilson Counseling/Wilson Place? _____

Assessment requested by: ☐ Self ☐ Court ☐ Attorney ☐ DCBS ☐ Other

**Please give a brief description of problem.**

_____

_____

_____

_____

_____

_____

Length of problem: _____ (months/years) Problem severity: ☐ Serious ☐ Moderate ☐ Minor

**Please check current or recent symptoms:**

| | | |
|---|---|---|
| ☐ Abuse (physical) | ☐ Excessive Energy | ☐ Panic Symptoms |
| ☐ Abuse (sexual) | ☐ Financial Stress | ☐ Overreact often |
| ☐ Abuse (emotional) | ☐ Focus problems | ☐ Opposition or Disrespectful |
| ☐ Anxiety | ☐ Grief | ☐ Relationship Problems |
| ☐ Depressed mood | ☐ Hallucinations | ☐ Self-harm thoughts |
| ☐ Dislike of self | ☐ Impulsive Behavior | ☐ Sleep Problems |
| ☐ Divorce/Separation | ☐ Irritability | ☐ Suicidal Thoughts |
| ☐ Eating Problem | ☐ Loss of Interest | ☐ Suspiciousness |
| ☐ Excessive Anger | ☐ Memory Problems | |

If you have experienced suicidal thoughts or have previous attempts, when? _____

**Previous Mental Health Services**

Name of Provider_____ Inpatient ☐ Outpatient ☐ Year _____

Reason/Diagnosis _____

Name of Provider_____ Inpatient ☐ Outpatient ☐ Year _____

Reason/Diagnosis _____

**Please list person who live with you.**

| Name | Relationship | Age | How you get along |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Please list supportive person in your life (friends or family).**

| Name | Relationship | Age | How you get along |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

If your parents separated or divorced, how old were you? _____

Did you have any problems in utero, infancy, or early childhood? _____

How would you describe your childhood? ☐ Very pleasant ☐ Pleasant ☐ Difficult ☐ Very difficult

**CLIENT NAME:** _____

**Family history of mental health issues**

☐ None ☐ Depression ☐ Anxiety ☐ Alcohol/Drugs ☐ Other

Father _____

Mother _____

Siblings _____

Father's Family _____

Mother's Family _____

**Health (Please check conditions you have experienced)**

☐ HIV/AIDS/Hepatitis ☐ Seizures ☐ Tics

☐ Diabetes ☐ Allergies ☐ STDs

☐ Liver Disease ☐ Hospitalization ☐ Pregnant

☐ Headaches ☐ Asthma ☐ None

☐ Heart Disease ☐ Cancer Other_____

**Please list any drug or food allergies**.

_____

**Please list all medications you are currently taking:**

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Who prescribes the mediation? _____

Who is your current Primary Care Provider? _____

Permission to release information to you Primary Care Provider? ☐ Yes ☐ No

**Cultural Preferences**

Faith-based beliefs: _____ Ethnicity: _____

**Educational History**

Are you currently a student? Yes ☐ No ☐ School _____ Grade _____

Did you have learning difficulties? Yes ☐ No ☐ Behavior problems at school? Yes ☐ No ☐

How much do you enjoy school? A lot ☐ Some ☐ Little ☐ None ☐

**CLIENT NAME:** _____

**Work History**

Are you currently employed? Yes ☐ No ☐ If yes, where? _____ How long? _____

Employer phone number? _____

How much do you like your job? A lot ☐ Some ☐ Little ☐ None ☐

**Alcohol/Substances**

Alcohol use: Several drinks daily ☐ Several drinks weekly ☐ A few drinks a month ☐ None ☐

Substance use: Currently use ☐ Used in Past ☐ Never used ☐

**Legal History**

Do you have an active court case? Yes ☐ No ☐ Court/Judge: _____

Do you have another court date? Yes ☐ No ☐ If yes, when? _____

Do you have an open DCBS case? Yes ☐ No ☐ If yes, worker: _____

Have you ever been the perpetrator of abuse? If yes, when? _____

**Social History**

How many friends do you have? None ☐ Few ☐ Some ☐ Many ☐ A lot ☐

What are your interests or hobbies? _____

What are your strengths or things you like about yourself? _____

What are things you want to change about yourself? _____

**Are you currently participating in any of the following community services?**

Family Enrichment Center ☐ Child Advocacy Center ☐ BRASS ☐

DCBS ☐ Hope Harbor ☐ Other ☐

**CLIENT NAME:** _____

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# TARGETED CASE MANAGEMENT SCREENING

***Complete TCM Screening Tool if 4 or more are checked***

**What areas of your life do you need resources or guidance to increase your overall well-being? (circle all that apply)**

**Housing Health Employment Legal Relational Nutrition/Food Transportation Education**

**1. Do you have Medicaid?**
- ☐ Yes
- ☐ No

**2. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?**
- ☐ Yes
- ☐ No

**3. Within the past 6 months, you worried that your food would run out before you got money to buy more.**
- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

**4. Within the past 6 months, the food you bought just didn't last and you didn't have the money to buy more.**
- ☐ Yes
- ☐ No

**5. Do you put off or neglect going to the doctor because of distance or transportation?**
- ☐ Yes
- ☐ No

**6. In the past 6 months has the electric, gas, oil, or water company threatened to shut off services in your home?**
- ☐ Yes
- ☐ No

**7. Do problems with child care make it difficult for you to work or study?**
- ☐ Yes
- ☐ No

**8. Do you have a job?**
- ☐ Yes
- ☐ No

**9. Do you have a high school degree/GED?**
- ☐ Yes
- ☐ No

**10. How often does this describe you? I don't have enough money to pay my bills:**
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

**11. Would you like help with any of these needs?**
- ☐ Medical care
- ☐ Dental care
- ☐ Vision care
- ☐ Psychiatric care
- ☐ Referral for providers

**12. Do you have involvement with DCBS or court?**
- ☐ Yes
- ☐ No