INTAKE INFORMATION PROFILE

GENERAL INFORMATION

Name: _____ Age: _____ Gender: _____

Occupation: _____ Employer: _____

Address: _____

Phone Number: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Education: High School (last grade completed): _____ College : ☐ Yes ☐ No

Other Training? (list type and years) _____

HEALTH INFORMATION

Please rate your physical health: ☐ Very good ☐ Good ☐ Average ☐ Declining

Any recent weight changes (gained or lost)? _____

List important present or past illnesses or injuries: _____

_____

Physician's name: _____ Date of last exam? _____

Presently taking medication? ☐ Yes ☐ No If yes, please list: _____

For what reason are you taking the medication? _____

Have you been treated by a psychiatrist? ☐ Yes ☐ No If yes, when? _____

If yes, how long? _____ Name of psychiatrist (if applicable): _____

EMOTIONAL INFORMATION

Have you ever had a severe emotional disturbance or trauma? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever had counseling/therapy in the past? ☐ Yes ☐ No

If yes, list previous counselor(s)/therapist(s) and dates: _____

Please describe your experience with any previous counselor(s)/therapist(s). What was, or was not, helpful or effective? _____

_____

Describe your current social support? Is it adequate? _____

_____

Do you have any previous legal history? ☐ Yes ☐ No If yes, please describe: _____

SUICIDE INFORMATION

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1-10 (10 being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

SUBSTANCE USE INFORMATION

Do you use caffeine? ☐ Yes ☐ No Amount per day? _____

Do you consume alcohol? ☐ Yes ☐ No Amount per day? _____

Do you use any recreational drugs? ☐ Yes ☐ No If yes, what substances? _____

Please list any other addictions: _____

MARITAL INFORMATION

Are you married? ☐ Yes ☐ No Date of marriage? _____

If YES, please answer the following. If NO, please skip to the next section.

Spouse's Name: _____ Age: _____ Phone: _____

Address: _____ _____ Occupation: _____

Education: High School (last grade completed) _____ College _____ (how many years) _____

Other Training? (list type and years) _____

Has either of you filed for divorce? ☐ Yes ☐ No Any previous marriages? ☐ Yes ☐ No

Children's names and ages: _____

FAMILY OF ORIGIN INFORMATION

Were you raised by anyone other than your birth parents? ☐ Yes ☐ No

If yes, please explain _____

_____

Did one or both of your parents die while you were a child? ☐ Yes ☐ No If yes, how old were you? _____

Are your parents divorced? ☐ Yes ☐ No If yes, when? _____

Age of parents, if living: Mother: _____ Father: _____

Father's occupation: _____ Mother's occupation: _____

Was your parents' marriage: ☐ unhappy ☐ average ☐ happy ☐ very happy ☐ I am not sure

As a child were you closest to: ☐ father ☐ mother ☐ someone else (who?):_____

Was your childhood: ☐ unhappy ☐ average ☐ happy ☐ very happy

Please list your siblings in birth order, giving their age and including yourself in the list

_____

COUNSELING INFORMATION

What brings you here currently? _____

_____

_____

_____

_____

Have you done anything about this concern so far? If so, please explain: _____

_____

_____

What do you hope to get from this counseling experience? _____

_____

_____

_____

Other information you feel I should know? _____

_____

_____

Please place a checkmark next to any of the following symptoms that you may have experienced in the past year. If any symptoms are repeated on this form, please check them again. Thank you!

- ☐ A persistent sad, anxious or "empty" mood
- ☐ Sleeping too little or sleeping too much
- ☐ Reduced appetite and weight loss or increased appetite and weight gain
- ☐ Loss of interest or pleasure in activities once enjoyed
- ☐ Persistent physical symptoms that don't respond to treatment
- ☐ Difficulty concentrating, remembering, or making decisions
- ☐ Fatigue or loss of energy
- ☐ Feeling guilty, hopeless or worthless
- ☐ Thoughts of death or suicide
- ☐ Disorganized thinking
- ☐ Disorganized speech
- ☐ Difficulty expressing your emotions
- ☐ Diminished or loss of contact with reality
- ☐ Withdraw from other people
- ☐ Hallucinations
- ☐ Feelings of grandiosity
- ☐ Get tired easily
- ☐ Concentration problems and mind going blank
- ☐ Muscle tension
- ☐ Preoccupation with details, lists, order, organization, rules, or schedules
- ☐ Perfectionism that interferes with the completion of the task
- ☐ Excessive devotion to work
- ☐ Place great value on rules
- ☐ Difficulty throwing out worn-out, useless, or worthless objects, with no sentimental value
- ☐ Insist others work or do task exactly as they should
- ☐ View money as something to be hoarded
- ☐ Told by others that you are stubborn and rigid

☐ Thoughts or impulses that are distressful, persistent and recurrent. These thoughts or impulses may not just be worries of real-life problems. You are aware that these thoughts or impulses are only a product of your own mind and you try to actively suppress, ignore, or neutralize them with other actions.

☐ Engage in repetitive behavior, physical or mental that cannot be controlled. (E.g., washing hands, checking locks, praying repeatedly, counting or saying words repeatedly) These actions help you to prevent or reduce some distressful situation.

☐ Re-experience a trauma over and over again in dreams, nightmares or painful memories

☐ Anxiety

☐ Depression

☐ Diminished ability to experience emotion or intimacy

☐ Problems falling or staying asleep

☐ Persistent fear of social or performance situations

☐ Feel that your behavior will be scrutinized by others and lead to embarrassment

☐ Have different personality states that surface in your life on a recurring basis

☐ Feel detachment or distance from your own experience, body, or self (feel like you are in a dream)

☐ Feel out of control of your actions and movements

☐ Feel like the external world is unreal or distorted

☐ Refuse to eat which leads to a below normal body weight

☐ Binge eating followed by self-inducing vomiting, misusing laxatives, fasting, or excessive exercise

☐ Act on a certain impulse, that is potentially harmful, but they cannot resist

☐ Believe that others are exploiting, harming, or trying to deceive you

☐ Experience doubts about friends or others loyalty or trustworthiness

☐ Believes that if you confide in others, this information somehow will be used against you

☐ Finds demeaning or threatening meanings in people's remarks or events

☐ Find it hard to forgive and bear grudges

☐ Find that people are out to attack your character or reputation

☐ Believes there maybe infidelity of your sexual partner

☐ Avoid activities with other people

☐ Avoid getting involved due to a fear of not being liked by others

☐ Restrain yourself in intimate relationships due to a fear of shame or ridicule

☐ Concern you may be rejected or criticized by others

☐ Stay away from new situations with people due to feelings of inadequacies

☐ Views yourself as inferior, socially inept, or personally unappealing

☐ Take few if any personal risks in the engagement of new activities, for a fear of being embarrassed

☐ Rapid changes in mood

☐ Find yourself going to about any lengths to avoid feeling abandoned

☐ Find yourself in relationships that are often difficult or stormy

☐ Have difficulty figuring out who you are and what you stand for

☐ Impulsive in areas of your life that are self-damaging such as sex, spending, eating, driving recklessly, etc.

☐ Have you ever thought about or actually cut or scratched yourself intentionally

☐ Frequently have feelings of emptiness

☐ Frequently feel angry

☐ Have a hard time in making everyday decisions with out getting reassurance and advice from others

☐ Have others assume the responsibility for the major areas of your life

☐ Have difficulty disagreeing with others for fear of being rejected

☐ Difficulty in doing things on their own

☐ Will do almost anything to get the support of others

☐ Feel uncomfortable or helpless when alone

☐ When one caring or supportive relationship ends, you are compelled to seek another

☐ A fear of being left alone to care for yourself

☐ Uncomfortable if you are not the center of attention

☐ Interact with others in a provocative or seductive manner

☐ Rapid changing of emotion

☐ Use your appearance to draw attention

☐ Have been told you are theatrical or very emotional

☐ Easily influenced by others

☐ Feel that most sociable relationships are intimate.

☐ Have fantasies or are preoccupied with your beauty, brilliance, ideal love, power, or success

☐ Have a need to associate with people of high status

☐ A need for excessive admiration from others

☐ Have an expectation of being treated with favor by others

☐ Expect an automatic compliance to your wishes

- ☐ Sometimes use others to achieve your goals
- ☐ Find it difficult to empathize with others
- ☐ Often feel envious of others
- ☐ Stubborn and rigid
- ☐ Wish not to have or to enjoy close relationships with family or friends
- ☐ Prefer solitary activities and life
- ☐ Has little or no interest in sex with a partner
- ☐ Have little or no pleasure when doing activities
- ☐ Have few if any close friends other than relatives.
- ☐ Do not feel emotions connected with praise or criticism
- ☐ Have increased energy, activity, and restlessness
- ☐ Have "high" or euphoric moods often
- ☐ Irritability
- ☐ Racing thoughts and talking very fast, jumping from one idea to another
- ☐ Distractibility, can't concentrate well
- ☐ Little sleep needed
- ☐ Unrealistic beliefs in one's abilities and powers
- ☐ Poor judgment at times
- ☐ Spending sprees
- ☐ A lasting period of behavior that is different from your usual behavior
- ☐ Increased sexual drive
- ☐ Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- ☐ Aggressive behavior such as yelling or hurting others

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life: for each question below, please answer once from your child's perspective and once for yourself.

#	Question	Answer
1	**Question 1** Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? *or* Act in a way that made you afraid that you might be physically hurt?	☐ Yes ☐ No If yes, enter 1: _____
2	**Question 2** Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? *or* Ever hit you so hard that you had marks or were injured?	☐ Yes ☐ No If yes, enter 1: _____
3	**Question 3** Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? *or* Try to or actually have oral, anal, or vaginal sex with you?	☐ Yes ☐ No If yes, enter 1: _____
4	**Question 4** Did you often feel that … No one in your family loved you or thought you were important or special? *or* Your family didn't look out for each other, feel close to each other, or support each other?	☐ Yes ☐ No If yes, enter 1: _____
5	**Question 5** Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? *or* Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐ Yes ☐ No If yes, enter 1: _____
6	**Question 6** Were your parents ever separated or divorced?	☐ Yes ☐ No If yes, enter 1: _____

#	Question	Answer
7	**Question 7** Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? *or* Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? *or* Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐ Yes ☐ No If yes, enter 1: _____
8	**Question 8** Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐ Yes ☐ No If yes, enter 1: _____
9	**Question 9** Was a household member depressed or mentally ill or did a household member attempt suicide?	☐ Yes ☐ No If yes, enter 1: _____
10	**Question 10** Did a household member go to prison?	☐ Yes ☐ No If yes, enter 1: _____

Total "Yes" answers: _____ (ACE Score)

CONNECTIONS COUNSELING, LLC
900 Corbitt Drive
Wilmore, KY 40390
Rhealynn Clark // 859-509-8468 // Rhealynn@kyconnections.com
Alex Clark // 859-806-9813 // Alex@kyconnections.com

Request and Authorization for the Release of Information

Patient Information

Name: _____ Birth Date: _____

I, _____, authorize Connections Counseling, LLC. to:

☐ Receive from ☐ Disclose to

Name of Agency or Facility: _____

Street Address: _____ City/State/Zip _____

The following specific information will be received/disclosed from the above named patient's record:

☐ Evaluation/Assessment ☐ Treatment/Service

☐ Other: _____

Date(s) of treatment: _____

I understand the purpose of this disclosure is for: ☐ Use in treatment ☐ Other: _____

I hereby release the above-named agency from all liability that may arise from the release of information requested. I expect that the information will be handled in a confidential manner.

Time Limitation: This authorization expires one year from the date of signature of the client. This release is subject to revocation at any time. I acknowledge that I have read and fully understand this authorization.

Client Signature: _____ Date: _____

Witness: _____ Date: _____

Please send via mail to:

Connections Counseling, LLC
900 Corbitt Drive
Wilmore, KY 40390

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900 Corbitt Drive
Wilmore, KY 40390

Alex Clark, M.A., M.Div., LMFT #169304 – 859-806-9813
Rhealynn Clark, M.A., LPCC #102212 – 859-509-8468

Informed Consent

1. **Counseling Approach**
   We use a variety of interventions to assist you. Depending on your needs, we may use various Trauma and Attachment Therapy Modalities, Play Therapy, PCIT, TheraPlay, Sand Tray Therapy, Cognitive Behavioral Therapy, and/or Emotion Focused Therapy, or other therapies as needed. Your care may also include elements of Christian faith as desired.

2. **Goals**
   Specific goals will be developed and mutually agreed upon. The goals may be specific (change in behavior, improved relationships), or more general (less anxiety, better self-esteem). The length of therapy depends on the complexity/ severity of your problems.

3. **Fees**
   Fees are on a sliding scale basis, and are due via cash, check, debit card, or credit card at the time of the session. HSA/FSA payments are also available. We do not bill insurance. We cannot guarantee that an insurance company will reimburse you for services. A $40 fee will be charged for checks that are returned for insufficient funds. Services thereafter will be on a cash or debit/credit card only basis. Your fee for services will be based on a sliding scale according to your family's gross yearly income. Yearly income includes income such as child support payments, maintenance (alimony), and disability payments. Sessions are billed on an hourly rate for the first scheduled hour, and in fifteen-minute increments thereafter. Most sessions will last one hour, but there may also be times where Rhealynn or Alex can decide to provide additional time to complete the therapeutic work in session that day. At Rhealynn or Alex's discretion, sessions can be scheduled on Saturdays with an increased fee.

Please check on the line below to determine the hourly fee for services:

	Yearly Gross Income	Hourly Fee
_____	$0 to $59,999	$85.00
_____	$60,000 to $69,999	$95.00
_____	$70,000 to $79,999	$105.00
_____	$80,000 to $89,999	$115.00
_____	$90,000 to $100,000	$125.00
_____	$100,000 and above	$135.00

4. **Sessions**
   Sessions will begin and end on time. If you arrive late for a session, your session time will be shortened and your normal fee will be expected. Please call 24 hours in advance if you need to change or cancel your appointment. Your appointment time has been reserved just for you. If you do not provide a 24-hour notice or if you fail to keep a scheduled appointment, you will be required to pay a fee, which will be a portion of your hourly rate.

5. **Legal Proceedings**
   It is our policy not to testify in court custody/divorce hearings. If you are coming for support during a stressful time in your life, then the therapist's work is directed toward helping you in therapy. Participating in court proceedings is often counterproductive to the therapy process. By setting this policy at the beginning of therapy, the therapy room is kept as a safe place to work through emotions. By signing this informed consent, you agree not to subpoena or ask for court testimony/evaluations from Rhealynn Clark, Alex Clark, or Connections Counseling as an agency.

You also agree to instruct your attorneys not to subpoena Rhealynn, Alex, or Connections Counseling as an agency or refer to Rhealynn, Alex, or Connections Counseling as an agency in a court filing. In the event that we are asked to appear in court or provide a deposition, there will be a fee of $200.00 per hour which includes travel time to and from the location requested.

6. **Benefits and Risks of Therapy for Adults**

Counseling may involve discussing relational, spiritual, psychological, and/or emotional issues that may be distressing. There is no guarantee of outcomes as a result of participating in upcoming sessions. At any point during the counseling process, we may deem it in your best interests to be referred to another professional. If you are involved in violence, substance abuse, or have threatening behavior, we may discontinue your therapy and give you an appropriate referral. You have the right to discontinue counseling at any time. We will not reveal your identity as a client to others. Therefore, we will not address you first if we meet you somewhere in public. We will decline any social invitations, as once we engage in our role as your counselor, we will always remain in that role in order to best preserve confidentiality. These guidelines are not meant to be discourteous in any way. They are meant for your long-term protection.

7. **Confidentiality for Adults**

The therapist will keep everything you say completely confidential, with the following exceptions:

- You sign a release of information and authorize us to talk to someone else.
- We determine that you are a danger to yourself or to others.
- You report information about the abuse of a child, elderly person, or a disabled individual who may require protection.
- You report information regarding someone else being in imminent danger.
- When we are ordered by a judge to disclose information even after asserting professional privilege.
- You file a complaint or lawsuit, and while defending themselves, Rhealynn, Alex, or Connections Counseling as an agency may disclose personal information.
- In couple and family guidance, we do not view confidentiality as applying between a couple and/or family members and will use clinical judgment regarding sharing information.

8. **Telehealth**

Prior to providing telehealth services, adult clients or parent/guardian(s) of a minor shall be required to produce a valid photo identification. Also, an initial assessment will be completed to determine if telehealth is an appropriate delivery of treatment. Telehealth may not be appropriate if there are, or likely to be, recurrent crises or emergencies, or if there is, or likely to become, a risk of harm to self or others. Telehealth services may be terminated at our discretion if we deem it is in your best interests to be referred to another professional or in-person care. You have the right to discontinue telehealth services at any time. Telehealth services will be synchronous and conducted via a HIPAA compliant platform with built in information encryption and security. In case of technological difficulties, the therapist will call the client to arrange alternate methods of delivery.

9. **Emergency Care**

If you have an emergency, please call 911 or go to your local emergency room. We do not provide crisis stabilization or after-hours care. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

10. **Child Care and Safety on the Premises**

No provision is made for child care. If your child/children is not participating in a session, please make other arrangements for his/her care. Connections Counseling is not responsible for any accidents or injuries to children who are unsupervised by their parents on the property.

10. **Homework**
    Homework is an important part of the growth that you will make and may be given at each session attended.

11. **Documentation Requests**
    We can provide written summaries of assessments, therapeutic progress, or other reports as needed. There is a fee associated with this service. All documentation and client information is stored securely.

12. **Communication and Social Media Policy**
    We do not engage with active clients via social media platforms. Communication is maintained through the therapeutic relationship while clients are participating in services with us. You can contact us between sessions via phone or email, and we will respond at our earliest convenience. If you cannot reach us and have an emergency, please call 911 or go to your local emergency room.

Please sign below that you have read, understand, and agree to comply with the above policies.

Name (printed): _____

Signature(s): _____

Date: _____

Email address (for Square invoices and correspondence):_____