Jeffrey D. Bishop MA LMHC Inc
752-B Blanding Blvd., Suite 133
Orange Park, FL 32065
Phone: (904) 228-7148

Adult Intake Forms

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

Nick Names: _____ Name You Prefer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Street Address: _____ Suite or Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ Extension: _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live *(Check All that Apply)*: ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling, Step)*	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Pease Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back If Necessary)*:

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed *(Use Back If Necessary)*:

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches ☐ Past ☐ Present	Dizziness ☐ Past ☐ Present	Stomach Trouble ☐ Past ☐ Present
Visual Trouble ☐ Past ☐ Present	Sleep Trouble ☐ Past ☐ Present	Trouble Relaxing ☐ Past ☐ Present
Weakness ☐ Past ☐ Present	Tension ☐ Past ☐ Present	Rapid Heart Rate ☐ Past ☐ Present
Difficulty Breathing ☐ Past ☐ Present	Intestinal Trouble ☐ Past ☐ Present	Hearing Noises ☐ Past ☐ Present
Change in Appetite ☐ Past ☐ Present	Tiredness ☐ Past ☐ Present	Pain ☐ Past ☐ Present
Hearing Voices ☐ Past ☐ Present	Seeing Things ☐ Past ☐ Present	Other ☐ Past ☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Changed in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress ☐ You ☐ Family	Nervousness ☐ You ☐ Family	Anxiety ☐ You ☐ Family
Panic ☐ You ☐ Family	Unhappiness ☐ You ☐ Family	Depression ☐ You ☐ Family
Guilt ☐ You ☐ Family	Apathy ☐ You ☐ Family	Terminal Illness ☐ You ☐ Family
Recent Death ☐ You ☐ Family	Grief ☐ You ☐ Family	Hopelessness ☐ You ☐ Family
Inferiority Feelings ☐ You ☐ Family	Defective Feelings ☐ You ☐ Family	Loneliness ☐ You ☐ Family
Shyness ☐ You ☐ Family	Fears ☐ You ☐ Family	Friends ☐ You ☐ Family
Marriage ☐ You ☐ Family	Communication ☐ You ☐ Family	Physical Abuse ☐ You ☐ Family
Emotional Abuse ☐ You ☐ Family	Verbal Abuse ☐ You ☐ Family	Sexual Abuse ☐ You ☐ Family
Temper ☐ You ☐ Family	Anger ☐ You ☐ Family	Aggressiveness ☐ You ☐ Family
Bad dreams ☐ You ☐ Family	Concentration ☐ You ☐ Family	Racing Thoughts ☐ You ☐ Family
Unwanted Thoughts ☐ You ☐ Family	Memory ☐ You ☐ Family	Loss of Control ☐ You ☐ Family
Impulsive Behavior ☐ You ☐ Family	Self-Control ☐ You ☐ Family	Compulsivity ☐ You ☐ Family
Sexual problems ☐ You ☐ Family	Pregnancy ☐ You ☐ Family	Abortion ☐ You ☐ Family
Legal Matters ☐ You ☐ Family	Trauma ☐ You ☐ Family	Eating Problems ☐ You ☐ Family
Drug Use ☐ You ☐ Family	Alcohol Use ☐ You ☐ Family	Trouble with Job ☐ You ☐ Family
Career Choices ☐ You ☐ Family	Ambition ☐ You ☐ Family	Making Decisions ☐ You ☐ Family
Children ☐ You ☐ Family	Being a Parent ☐ You ☐ Family	Finances ☐ You ☐ Family
Recent Loss ☐ You ☐ Family	Disaster ☐ You ☐ Family	Other ☐ You ☐ Family

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have you Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e., What Are Your Issues, Problems?)*: _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary)*:

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

_____

Complete the Following Thought: God Is _____

Do You Regularly Attend a Place of Worship: ☐ Yes ☐ No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

TERMS OF SERVICE

I Understand that it Is Customary to Pay for Professional Services when Rendered. I Accept Full Responsibility for Payment of Any Balance Incurred for Services. I Further Understand that Without 24-Hour Notice of Intention to Cancel, I Will be Charged the Full Fee for Professional Service.

Signed: _____ Date: _____

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INFORMED CONSENT AND RELEASE OF LIABILITY

The completion of an intake questionnaire, and an informed consent and release of liability are required for counseling services to commence. In order to initiate counseling, please read the following agreement; your signature attests that you both understand and agree to the terms contained herein.

1. I _____ understand that my counselor (or the counselor of the minor child named below) is a Licensed Mental Health Counselor (LMHC) in the state of Florida.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others, HIV/Aids reporting requirements, Patriot Act reporting requirements, court mandated requirements).

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby indemnify and hold harmless, release, remise and forever discharge and covenant not to sue or hold legally liable Jeffrey D. Bishop, M.A., LMHC from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling process. I waive any right I may otherwise have to seek to use the record of my counseling with Jeffrey D. Bishop, M.A., LMHC as evidence in any judicial proceeding or to compel his testimony.

4. I understand that giving my counselor notice of any need to cancel or change my scheduled appointments is necessary for the functioning of my counselor's practice, and that I will NOT receive appointment reminder calls/notifications unless I specifically make a request for this. I agree to give my counselor a **minimum of 24 hours notice by phone** in the event of needing to cancel or change my appointment, and I further agree to pay a **fee of $30** if failing to do so (unless prohibited by my EAP).

   Please Initial: _____

5. I agree that I am responsible for the fees for services provided by Jeffrey Bishop, M.A., LMHC to me (or to the minor client named below), even though other parties or insurance companies may make payments on my (or the minor client's) behalf.

   Please Initial: _____

I have read and understand the preceding information and agree to the policies as stated. I understand that these comments are prerequisite to my receiving and continuing counseling with Jeffrey D. Bishop, M.A., LMHC.

Signed: _____ Date: _____

(Print child's name if you are signing as parent/legal guardian of this client: _____)

Witnessed: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment,* and *health care operations:*

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.
- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the *Notice of Privacy Practices.* We will make and post revisions to the *Notice of Privacy Practices* in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information about HIPPA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (877) 696-6775 (TOLL FREE)

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____ have received a copy of Notice of Privacy Practices.
(Full Name)

Name: _____

Street Address: _____ Suite or Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____