CONFIDENTIAL CLIENT INTAKE

Stillpoint Counseling

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ACPE Psychotherapist

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Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information. Please bring it to our first session.

Name:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ▫ Male ▫ Female

Current Marital Status:

▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced
▫ Widowed

Your Mailing Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? ▫Yes ▫No
Cell/Other Phone: _____May I leave a message? ▫Yes ▫No

E-mail: _____May I email you? ▫Yes ▫No
*Please note: Email correspondence is not a confidential medium of communication.

Referred by (if any):

_____
May I thank them? Y N

Please indicate if and when you have now or have ever had any of the following conditions by placing an X in the proper column. If you have never had any of these conditions, please check here _____.

Name of Condition	Present	Past	Year
Congestive Heart Failure			
Angina			
Heart attack or myocardial infarction			
Stroke/Brain attack			
Hypertension or high blood pressure			
Kidney disease			
Cancer			
Chronic Lung disease			
Blindness or trouble seeing, even with glasses			
Deafness or trouble hearing			
Sugar diabetes			
Asthma			
Ulcer or gastrointestinal bleeding			
Arthritis or Rheumatism			
Psoriasis or other skin disease			
Sciatica or chronic back problem			
Other			

During the past 4 weeks, have you taken any prescription medicine? Please list them and the condition for which you took it.

_____
_____
_____
_____
_____

TELL ME A LITTLE ABOUT YOURSELF:

High School Diploma? Yes No **Business or Technical School?** Yes No

College: Number of Years ___ Degree(s):_____

Name of College(s):_____

How many people (including yourself) live in your household?

Number of adults_____ Number of Children_____

Please list the names and ages of your children and/or stepchildren:

_____

_____

Circle the category that best describes your household's total income?

Less than $40,000 $40,000-$69,999 $70,000-$99,999 More than $100,000

What is your occupation?_____

How long have you been in your current occupation?_____

Do you have a religious/spiritual tradition? Yes No

If so, what is your tradition? _____

How active are you in your religious tradition? _____

Have you had previous counseling? Yes No **When?**_____

With whom? _____

Are you presently seeing another Counselor? Yes No

How do you rate your current physical health?

Poor Fair Average Good Excellent

How do you rate your current emotional health?

Poor Fair Average Good Excellent

Please state in your own words the concerns you bring to counseling (use the back of the page if necessary)_____

_____

_____

_____

Circle the items that describe/relate to the concerns you bring to counseling

Anxiety	Frigidity	Religious Doubts
Bereavement	Sexual Orientation	Loss of faith in God
Depression	Fear	Loss of faith in self
Nervousness	Self Doubt	Loss of faith in others
Loneliness	Guilt	Loss of hope
Marriage Problems	Suicidal feelings	Loss of meaning
Sexual Concerns	Relationship with parents	Loss of love
Impotency	Relationship with children	Loss of self-respect

What is your main reason for seeing counseling? (circle all that apply)

Family	Marriage	Depression
Anxiety	Spiritual	Personal Growth
Substance Abuse	Vocational	Other

Emergency Contact _____

Relationship_____

Phone:_____

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy Law", HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, I am required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions about any of the matters discussed above, please do not hesitate to ask us for further clarification.

I have read and understood the Informed Consent Form, including the Client Notification of Privacy Rights section.

_____ _____

Signature of Client (or parent if Minor or Legal Charge) Date

INFORMED CONSENT FORM

PLEASE KEEP THIS INFORMATION FOR YOUR RECORDS

ABOUT YOUR THERAPIST: James (Jim) M. Norris, M.Div., LMFT

I am a senior therapist with 29 years of experience in the field. I hold a Masters of Divinity degree and am licensed by the Alabama Board of Examiners in Marriage and Family Therapy. I am a Clinical Fellow with the American Association for Marriage and Family Therapy and a Psychotherapist with the Association of Clinical Pastoral Educators.

My training is in Psychodynamic Psychotherapy and Bowen Family Systems Theory. In 2013, I completed level 1 training in Internal Family Systems Therapy and have done extensive work in this modality. I find it a powerful way to integrate the psychological and spiritual dimensions for healing, growth and transformation. I have completed level 2 in EMDR training and sometimes use this modality in conjunction with IFS especially in trauma work. Mindfulness Meditation and other Contemplative Practices also complement IFS therapy. I will also introduce Cognitive Behavioral Therapy with clients who wish to explore thought patterns that may be life limiting.

Most importantly, I seek to provide a safe space where clients can bring whatever issues are preventing them from living a life of emotional and spiritual wholeness. As clients experience understanding and compassion, a trusting foundation is established and healing, growth and transformation begin. It is a blessing to do this work and to see this happen in the lives of my clients. I appreciate your trust in me as we engage this process.

APPOINTMENTS: Your scheduled office appointment is a time specifically set aside for you. If you are unable to keep an appointment, please notify me at least 24 hours in advance of the time of the appointment. I must charge for the hour if you do not notify me.

FEES: My fee range is $90-$130 for a 1 hour session. Most therapy sessions are for 50 minutes. I accept cash or checks. Insurance is not accepted, and payment is expected at the time of the appointment.

CONFIDENTIALITY: All clients have a right to confidentiality. This includes all verbal, written and recorded data concerning your treatment, and may not be released without your written consent. Limitations to these rights are:

1) I have a legal duty to warn and protect persons threatening harm to self or others.
2) I have a legal duty to report to proper authorities any knowledge of abuse to children and vulnerable adults.
3) I have to comply with Alabama State Laws in regard to court ordered subpoenas.
4) Social Media: Because your confidentiality is important to me, I do not "friend" those with whom I work in counseling.

The ethical standards of my profession prohibit me from testifying in a legal process on your behalf. I will, however, help you emotionally prepare for legal actions.

ENDING COUNSELING: Your care and counseling with me is strictly voluntary and may be ended at your discretion. However, it is important that we discuss any decision to stop counseling. Normally, as counseling comes to the end, a final session will be scheduled.