THRIVE ALABAMA

MENTAL HEALTH COUNSELING INTAKE SHEET

Client: _____Date _____Therapist:_____

Circle One:

Completed by Client Caregiver/Family Member Client with Therapist Assistance

In your own words, why are you here today?

_____

_____

_____

_____

Please circle all current symptoms below that apply to you. If you are not sure about some of these, the therapist will review it with you during session. PLEASE GIVE THIS SHEET DIRECTLY TO THE THERAPIST.

Addiction ☐	Anger ☐
Anxiety ☐	Appetite ☐
Decreased Appetite Increased ☐	Compulsions ☐
Concentration Impairment ☐	Constipation ☐
Depressed Mood ☐	Destruction of property ☐
Diarrhea ☐	Dizziness ☐
Excessive Sweating ☐	Mood swings ☐
Feelings of Guilt ☐	Loneliness ☐
Fatigue/Tiredness Fear ☐	Hallucinations ☐
Feelings of Hopelessness ☐	Flashbacks of Traumatic Memories/Events ☐
Irritability ☐	Impulsivity ☐
Impaired Productivity at Work/School ☐	Indecisiveness ☐
Gambling excessively ☐	Memory Impairment ☐

Impaired Family/Marital Relationships ☐ Inability To Enjoy Activities ☐

Indecisiveness ☐ Overuse/Misuse of alcohol ☐

Nausea ☐ Overuse/Misuse of Marijuana or Drugs ☐

Obsessive compulsive symptoms ☐ Panic Attacks ☐

Pain — General ☐ Racing Thoughts ☐

Pain- Headache ☐ Paranoid Thoughts ☐

Restlessness ☐ Self-harm (cutting, burning) ☐

Sexual Difficulties ☐ Shakiness/Tremulousness ☐

Shopping/spending excessively ☐ Sleep Problems: waking early ☐

Sleep Problems - difficulty staying asleep ☐ Sleep Problems: nonrestorative ☐

Sleep Problems- difficulty falling asleep ☐ Suicidal Thoughts ☐

Tearfulness ☐ Aggression towards others ☐

Weight Gain ☐ Work Related Stress ☐

Weight Loss ☐ Other_____

_____

FOR OFFICE USE ONLY/CLIENT NAME & DATE OF SERVICE_____

Reviewed and Discussed with Client: _____

Therapist's Signature and Date

Other Data Reviewed and Evaluated for Comprehensive Client Care:

_____

_____

_____

Comments/Recommendations:

_____

_____

_____

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very 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. Did a parent or other adult in the household **often or very 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. 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
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very 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. Did you **often or very 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. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

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. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

thrivealabama

Formerly the AIDS Action Coalition

Informed Consent for Mental Health Services

Mental health services are based on a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client receiving mental health services, you have certain rights and responsibilities that are important for you to understand. Your mental health professional has corresponding responsibilities to you. These rights and responsibilities are described below.

Goals of Counseling

There can be many goals for mental health treatment. Some goals may be long-term goals such as improving your quality of life, learning to live with mindfulness, or self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing self-defeating behavior or decreasing/ending drug use. Whatever the goals, they will be set by clients, in collaboration with the mental health professional. The mental health professional may make suggestions on how to reach a goal but the client decides whether to act on any suggestions. Generally by the 5th session, the client and mental health counselor will agree on individualized treatment goals in a treatment plan.

Risks/Benefits of Counseling

Benefits. There are many potential benefits to mental health services. Services may help you develop self-understanding, improve coping skills, make behavioral changes, reduce symptoms of mental illness, improve the quality of your life, develop an improved sense of your dignity and worth as a human being, and other benefits as well.

Risks. Mental health treatment can be an intensely personal process that may elicit unpleasant memories or emotions. Progress may happen slowly or quickly. Clients sometimes make progress, only to go backwards after a time. Counseling challenges us to grow, and growth can be uncomfortable. Counseling requires active effort by clients. The majority of therapeutic work is undertaken by clients outside of session.

Appointments

Sessions will ordinarily be 50-60 minutes in duration and are scheduled at the front desk. The first session is generally 75-90 minutes in length. The frequency of sessions will be determined by you and your mental health professional. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, you are asked to provide 24 hour notice whenever possible.

Confidentiality and Privacy

Your mental health professional will make every effort to keep your personal information as confidential as possible, given legal and agency constraints. If you wish to have information released to persons not employed at Thrive Alabama, you will be required to sign a release of information/consent form before information will be released. There are limitations to confidentiality in mental health treatment. First, your Thrive Alabama mental health professional may consult with other Thrive Alabama staff involved in your care (e.g. physician, nurse, supervisor, social worker or another professional), so that you receive the best service and to

ensure service coordination. Second mental health professionals are mandated by law to report suspected child abuse/neglect, as well as suspected abuse/neglect of vulnerable adults. Third, if a mental health professional assesses a client is a serious safety risk to self or others, the mental health professional must take appropriate action to help maintain your safety. Last, should your mental health professional receives a court order or subpoena, she/he may be required to release some information. In such a case, your mental health professional will consult with other professionals and limit the release to only what is necessary by law.

Record Keeping

Your mental health professional will keep electronic records of your sessions, along with the agreed upon treatment plan identifying treatment goals. Records are kept to ensure positive direction to sessions, to provide continuity in service and to coordinate services with other Thrive Alabama staff involved in your care. Records will not be shared except with respect to the limits to confidentiality as discussed in the Confidentiality section above. Should you wish to have your records released, you are required to sign a release of information which specifies what information is to be released and to whom.

Telephone Calls, Texts, Social Media

The mental health professional may not be available immediately by phone because she/he is with other clients or in necessary meetings. Mental health professionals will not generally answer phones when with clients. Thrive Alabama phones are not answered 5 pm - 8 am Monday-Thursday, 12 -5 pm Fridays, or on weekends. At these times, you may leave a message on the professional's confidential voicemail. Your call will be returned as soon as possible. Please know that it may take 1-2 business days to return calls regarding non-urgent matters. If you believe you cannot wait for a return call or you have an emergency, call Crisis Services 24.7 HELP line at 256.716.1000; call 1.800.273.TALK (8255) for suicide prevention; call 911 or go to the nearest hospital ER. The mental health professional, according to policy, does not text clients and does not use personal social media accounts (e.g. Facebook) interact with clients.

Ending Therapy

Your participation in therapy is voluntary and you have the right to end services whenever you so choose. However, if you decide to exercise this option, you are encouraged to talk to your mental health professional about the reason for your decision. Likewise, at the discretion of your mental health professional, she or he may end therapy and provide you with appropriate referrals. Some reasons for termination of services could be failure to attend sessions on a consistent basis or a belief that another provider may be a more appropriate. Please note that if you do not show for 3 appointments, NOT including cancellations and rescheduling, then the MHC will no longer schedule regular appointments with you. In this case, you may call Thrive-Alabama to see if the MHC has a cancellation and you may receive that spot on the schedule. When regular attendance is reestablished, the MHC will begin to schedule regular appointments with you again.

Consent to Mental Health Services at Thrive Alabama

Your signature below indicates you have read this Agreement and agree to its terms.

Client's Printed Name _____Date_____ DOB_____

Client Signature _____ Date_____

Witness _____ Date_____

thrivealabama

Formerly the AIDS Action Coalition

Informed Consent for Telehealth Services in Behavioral Health

1. I understand that my behavioral health professional wishes me to engage in a telehealth services. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

2. I understand my behavioral health professional's explanation regarding how videoconferencing and any other technology that will be used to affect such a session will not be the same as face-to-face contact, including the fact that I will be in a different physical location than my behavioral health professional.

3. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand there are potential risks to this technology, including but not limited to, interruptions and/or breaches of confidentiality by unauthorized persons, unauthorized access, and disruption of transmission by technology failures, and/or limited ability to respond to emergencies.

4. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs when videoconferencing is being used to provide services, then the session will be resumed by phone counseling if the technical difficulty is not resolved in a timely manner. If phone counseling sessions are interrupted (e.g. intermittent cell phone service), the behavioral health professional and client will seek to reconnect as soon as feasible. Clients may call the Department of Behavioral Health directly to reschedule a telehealth session interrupted by technical difficulties.

5. I understand that there will be no recording of any of the online sessions by any party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

6. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding). My behavioral health professional will be in a secure, stationary space alone to conduct my telehealth session in order to protect my privacy and I agree to be in a secure, stationary space alone to protect my privacy. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

7. I understand that I cannot assume that my behavioral health professional has access to any or all of the technical information about technological platforms such as Zoom for Healthcare – or that such information is current, accurate or up-to-date. I will not rely on my behavioral health professional to provide such information about technology.

8. I understand that my behavioral health professional will need to know my location in case of an emergency. I agree to inform my behavioral health professional of the address where I am located at the beginning of each session. I will also provide my behavioral health professional a contact person who they may contact on my behalf in a life-threatening emergency only. This person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

9. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

10. I understand that in the event of any mental health emergency outside of my behavioral health professional's regular operation, I will l call Crisis Services 24.7 HELP line at 256.716.1000; call 1.800.273.TALK (8255) for suicide prevention; or call 911 or go to the nearest hospital ER. I understand that my behavioral health professional is not available outside established hours for mental health treatment (8 am-5 pm unless otherwise noted).

11. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

12. I have had a direct conversation with my behavioral health professional, during which I had the opportunity to ask questions in regard to this service. 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 this form, I certify:

- I have read or had this form read and/or had this form explained to me and I agree to its terms.
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- I have received a copy or been offered a copy of this document.

Client's Printed Name _____Date_____ DOB_____

Client Signature _____ Date_____

Witness Printed Name_____ Date_____

Witness's Signature _____ Date_____