



INTAKE FORM

Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: M F

Email Address _____

Address _____ Phone: _____

May I call you there? _____ May I leave a message? _____

Work Address _____ Phone: _____

May I call you there? _____ May I leave a message? _____

Emergency Contact _____ Phone: _____

(Name and Relationship)

Current Marital Status and Length: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name: _____

Immediate Family:

Name	Age	Relationship	Where do they live?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Religious Preference: _____ Member of Local Church (which): _____

Have you been in counseling previously? YES NO

If so, please provide the name of the counselor you saw: _____

Are you currently in counseling? YES NO

If so, please provide the name and location of the counselor: _____

If you answered yes to the previous question please answer the following:

- a. How long have you been in counseling? Years _____ Months _____
- b. How many counselors have you seen? _____
- c. Was counseling for the treatment of the current problem? YES NO

Were you referred here? YES NO If yes, by whom: _____

How did you hear about BFTI? _____

Are you on any type medication? YES NO

If yes, what medication _____

Briefly describe your current physical health and any health problems currently being treated: _____

Who is your current physician? _____

Previous major illnesses or major hospitalizations: _____

Please indicate with a check mark any of the following issues that are a concern for you at this time or have been a concern in the past.

Please rank the three [3] most important concerns from 1, 2, 3 with 1 being the most urgent.

- | | | |
|--|--|---|
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Academic concerns | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Parent difficulty |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Child sexual abuse | <input type="checkbox"/> Suicidal thoughts/behavior |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Homicidal thoughts/behavior |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Anger control |
| <input type="checkbox"/> Sleeping difficulty | <input type="checkbox"/> Sexual orientation concerns | <input type="checkbox"/> Violent behavior |
| <input type="checkbox"/> Eating difficulty | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Other drug abuse | <input type="checkbox"/> Excessive fears |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Social concerns | <input type="checkbox"/> Obsessive thoughts/behavior |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Culture related issues | <input type="checkbox"/> Compulsive thoughts/behavior |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Dependency | <input type="checkbox"/> Hallucinations |

Brief statement of concern (Why are you seeking counseling? What would you like to see different in your life as a result of counseling?) _____

Is there any additional information you feel would help the counselor better understand your needs? _____



CONSENT FOR SERVICES

The **Bison Family Therapy Institute** offers a range of personal, psychological, family and education-related counseling. All of the BFTI Counselors are well-trained professionals with specific training and education in the field of counseling/therapy.

The **Bison Family Therapy Institute** adheres to ethical standards and professional guidelines regarding confidentiality. All information disclosed during the counseling session is confidential and will not be released without your signed permission. At times the counselors may consult with each other, but confidentiality will be maintained within the counseling office. There are some exceptions to this rule of confidentiality.

Confidentiality may be broken without prior consent only in extremely rare situations:

1. To report suspected child or elder abuse,
2. If there is evidence that the client poses a clear and imminent danger to self or others.

The contents of any or all counseling sessions may also be revealed if:

3. The Bison Family Therapy Institute or your counselor is ordered to do so by a court of law, or
4. If the client signs a release of information form allowing the **Bison Family Therapy Institute** to provide specific information regarding counseling sessions to specific parties.

THE FIRST VISIT: The first appointment is used to give the counselor and the client a chance to determine what needs and goals the client may have. This assessment period provides the counselor with the chance to make appropriate referrals and to assist the client in setting goals for counseling.

CANCELLATIONS/MISSED APPOINTMENTS: The **Bison Family Therapy Institute** should be contacted by phone at least 24 hours prior to the scheduled session if it is necessary to cancel the appointment.

CONSENT

I/We hereby consent to treatment with the **Bison Family Therapy Institute** and agree to participate in counseling or other services deemed appropriate and to continue such services as deemed necessary. I/We agree to be actively involved in the treatment plan as determined by myself, my counselor and the **Bison Family Therapy Institute** treatment team while I/we receive services. I/We understand that included in this treatment plan may be my/our involvement in regular family, individual, or group counseling sessions. I/We understand that no guarantees have been given by anyone as to the results that may be obtained.

I/We acknowledge that I/We

- Have received an orientation and a copy of the clients’ rights.
- Have been given an orientation to my rights concerning confidentiality.
- Have received, read, and understand the exceptions to confidentiality.
- Have read the Consent for Services, understand all of its contents and sign my name freely, voluntarily, and without coercion.

_____	_____	_____	_____
SIGNATURE OF CLIENT	DATE	SIGNATURE OF CLIENT	DATE

_____	_____	_____	_____
SIGNATURE OF CLIENT	DATE	SIGNATURE OF CLIENT	DATE

_____	_____
SIGNATURE OF COUNSELOR	DATE



CLIENTS' RIGHTS

- All clients have the right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for individual dignity.
- Each client has the right to receive services in a safe, sanitary, and humane living environment.
- Each client has the right to receive services in a humane psychological environment protecting them from harm, abuse, and neglect.
- Each client has the right to receive services in an environment that provides privacy, promotes personal dignity, and provides opportunity for the client to improve his/her functioning.
- Each client has the right to receive services without regard to his/her race, religion, gender, age, color, veteran's status, HIV/AIDS status, marital status, pregnancy, ethnic origin, national origin, degree of disability, handicapping condition, and/or legal status.
- No client shall ever be neglected or sexually, physically, verbally, financially, or otherwise abused.
- Each client has the right to be provided with prompt, competent, appropriate treatment services and an individualized treatment plan. The client shall be afforded the opportunity to participate in his/her treatment and treatment planning; and may consent, or refuse to consent, to the proposed treatment. The client's rights to consent, or refusal to consent, may be abridged for those clients adjudged incapacitated by a court or competent jurisdiction, and in emergency situations defined by law. When the client permits, the client's family and/or significant others shall be involved in the treatment and treatment planning.
- The records of each client shall be treated in a confidential manner.
- Each client has the right to refuse to participate in any research project or medical experiment without informed consent of the client, as defined by law. A refusal to participate shall not affect the services available to the client.
- Each client has the right to assert grievances with respect to any alleged infringement of these stated rights of clients, or any other subsequently statutorily granted rights.
- No client shall ever be retaliated against or subject to, any adverse conditions or treatment services solely or partially because of having asserted his/her rights as stated in this section.
- The client has the right to know about the results of activities in which he/she have participated.
- An individual can expect an explanation concerning the reason he/she was refused certain services.
- Client rights and privacy shall be protected by providing ways for the client to meet with the counselor in privacy.
- Clients have the right not to have their records released without their written authorization. Whenever a written disclosure is made, a written statement shall be included on the face of the document as follows:
"This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."
- Any client may request to speak with a supervisor to discuss their concerns about any service rendered or any concerns about a staff member's attitude or behavior.

Contact Info:

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