



4950 S. Apopka-Vineland Road
Orlando, Florida 32819
www.livingwatercounseling.com



INTAKE FORM

GENERAL INFORMATION

Date: _____ Referred by: _____

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

Name you prefer: _____

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

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

CONTACT INFORMATION

Street Address: _____ Ste./Apt. _____

City: _____ State: _____ Zip Code: _____

May we send mail here? Yes No

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

May we send mail here? Yes No

Home Phone: (_____) _____ May we leave a message here? Yes No

Cell Phone: (_____) _____ May we leave a message here? Yes No

Work Phone: (_____) _____ May we leave a message here? Yes No

Email Address: _____ May we send email here? Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Avg. Hours Worked/Week: _____

Average Annual Household Income:

\$0 to \$10,000 \$40,001 to \$50,000 \$80,001 to \$100,000

\$10,001 to \$20,000 \$50,001 to \$60,000 More than \$100,000

\$20,001 to \$40,000 \$60,001 to \$80,000

EDUCATION INFORMATION

Last Yr. of School: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are you currently in school? Yes No What level/degree are you pursuing? _____



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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: _____ 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 _____ Sex: Male Female

Partner's Occupation: _____ Avg. Hours Worked/Week: _____

Last Yr. 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 Date of Death)	Relationship to You (natural, adopted, step, foster, etc.)	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 affected you positively or negatively:

Name	Sex	Current Age (or Date of Death)	Relationship to You (e.g., Mom, Step-Dad, Brother, etc.)	Occupation	Describe Him/Her

CURRENT STATUS

Please check any of the following problems which pertain to you and/or your family:

- | | | | | | |
|----------------------|--|--------------------|--|------------------|--|
| Stress | <input type="checkbox"/> You <input type="checkbox"/> Family | Nervousness | <input type="checkbox"/> You <input type="checkbox"/> Family | Anxiety | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Panic | <input type="checkbox"/> You <input type="checkbox"/> Family | Unhappiness | <input type="checkbox"/> You <input type="checkbox"/> Family | Depression | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Guilt | <input type="checkbox"/> You <input type="checkbox"/> Family | Apathy | <input type="checkbox"/> You <input type="checkbox"/> Family | Terminal illness | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Recent death | <input type="checkbox"/> You <input type="checkbox"/> Family | Grief | <input type="checkbox"/> You <input type="checkbox"/> Family | Hopelessness | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Inferiority feelings | <input type="checkbox"/> You <input type="checkbox"/> Family | Defective feelings | <input type="checkbox"/> You <input type="checkbox"/> Family | Loneliness | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Shyness | <input type="checkbox"/> You <input type="checkbox"/> Family | Fears | <input type="checkbox"/> You <input type="checkbox"/> Family | Friends | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Marriage | <input type="checkbox"/> You <input type="checkbox"/> Family | Communication | <input type="checkbox"/> You <input type="checkbox"/> Family | Physical abuse | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Emotional abuse | <input type="checkbox"/> You <input type="checkbox"/> Family | Verbal abuse | <input type="checkbox"/> You <input type="checkbox"/> Family | Sexual abuse | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Temper | <input type="checkbox"/> You <input type="checkbox"/> Family | Anger | <input type="checkbox"/> You <input type="checkbox"/> Family | Aggressiveness | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Bad dreams | <input type="checkbox"/> You <input type="checkbox"/> Family | Concentration | <input type="checkbox"/> You <input type="checkbox"/> Family | Racing thoughts | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Unwanted thoughts | <input type="checkbox"/> You <input type="checkbox"/> Family | Memory | <input type="checkbox"/> You <input type="checkbox"/> Family | Loss of control | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Impulsive behavior | <input type="checkbox"/> You <input type="checkbox"/> Family | Self-control | <input type="checkbox"/> You <input type="checkbox"/> Family | Compulsivity | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Sexual problems | <input type="checkbox"/> You <input type="checkbox"/> Family | Pregnancy | <input type="checkbox"/> You <input type="checkbox"/> Family | Abortion | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Legal matters | <input type="checkbox"/> You <input type="checkbox"/> Family | Trauma | <input type="checkbox"/> You <input type="checkbox"/> Family | Eating problems | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Drug use | <input type="checkbox"/> You <input type="checkbox"/> Family | Alcohol use | <input type="checkbox"/> You <input type="checkbox"/> Family | Trouble with job | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Career choices | <input type="checkbox"/> You <input type="checkbox"/> Family | Ambition | <input type="checkbox"/> You <input type="checkbox"/> Family | Making decisions | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Children | <input type="checkbox"/> You <input type="checkbox"/> Family | Parenting | <input type="checkbox"/> You <input type="checkbox"/> Family | Finances | <input type="checkbox"/> You <input type="checkbox"/> Family |
| Recent loss | <input type="checkbox"/> You <input type="checkbox"/> Family | Disaster | <input type="checkbox"/> You <input type="checkbox"/> Family | Other _____ | <input type="checkbox"/> You <input type="checkbox"/> 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



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Are you currently experiencing any suicidal thoughts? Yes No If yes, briefly describe: _____

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?) Use the back if needed.

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? _____

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, please 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: _____ Dose: _____ Improves Prevents Controls: _____

Medication: _____ Dose: _____ 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 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? _____

PREVIOUS COUNSELING

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back if necessary):

Therapist: _____ Location: _____ Dates: _____

Reason: _____

Therapist: _____ Location: _____ Dates: _____

Reason: _____

Therapist: _____ Location: _____ Dates: _____

Reason: _____

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? _____

Who is 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

Living Water Christian Counseling, which is a ministry of Church of the Ascension, is designed to offer counseling and coaching with a Christian framework to the local community and the Church. Counseling services are provided by Christian practitioners who have earned a Master's Degree in Counseling from an accredited graduate program, and who have been licensed by the State of Florida as Licensed Mental Health Counselors or provisionally licensed as Registered Mental Health Counselor Interns. Career and life coaching, as well as organizational development consulting, are offered by Christian practitioners who have earned a Master's Degree in organizational development, human resources, or related fields from an accredited graduate program.

The completion of an intake questionnaire and an informed consent and release of liability are required for counseling or coaching services to commence. Selected personality and/or vocational assessments may also be administered at an additional cost, with fees to be communicated in advance of administering such assessments.

In order to initiate counseling or coaching, 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 is a Licensed Mental Health Counselor or a Registered Mental Health Counseling Intern working under the supervision of a Licensed Mental Health Counselor, as specified by Florida law. I understand that my coach is not under licensure but is qualified by training in related fields and experience to provide career and life coaching.
- 2) I understand that my counseling and coaching records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling or coaching professions (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others, HIV/Aids reporting requirements).
- 3) In consideration of the benefits to be derived from the counseling or coaching, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Living Water Christian Counseling; the Episcopal Church of the Ascension; the Episcopal Diocese of Central Florida; the licensed mental health counselors; the registered interns; the coaches; the supervisors; church staff; Vestry members; or ministry leaders from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling or coaching process.

I waive any right I may otherwise have to seek to use the record of my counseling or coaching with Living Water Christian Counseling or Church of the Ascension, as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, registered mental health counseling intern, coach, or supervisor providing counseling or coaching to me through Living Water Christian Counseling or Church of the Ascension

I have read and understood the preceding information and agree to the policies of Living Water Christian Counseling, a ministry at Church of the Ascension, as stated. I understand that these comments are prerequisite to my receiving and continuing counseling or coaching through Living Water Christian Counseling.

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____

STATEMENT OF POLICIES AND PROCEDURES

COUNSELING/COACHING SESSIONS

Counseling or coaching sessions are available weekly. Sessions are scheduled to begin on the hour or half-hour and are 50 minutes in length. Please arrive on time to get the benefit from a full-length session.

SERVICE FEES

Professional service fees range from \$90 to \$125 per 50-minute session. Speak with your counselor/coach if you need to apply for a partial scholarship. Payment is due at the time of service. You may pay either by cash or by a check made payable to "Ascension." Returned checks will be charged a \$20 service fee. Should you be unable to pay for all or part of a session, please speak with your counselor/coach.

OFFICE HOURS

Office hours are by appointment. Should you need to contact your counselor/coach outside of your regularly scheduled appointment, please contact them by phone. Phone calls lasting more than 10 minutes will be treated as a therapy or coaching session and you will be expected to pay your normal session rate.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a "standing appointment." If you occasionally need to come at a different time, ask your counselor/coach, who will see if an alternative appointment time is available.

Repeated cancellations or "no-shows" will result in the loss of your standing appointment.

CANCELLATIONS

If you must cancel your appointment, please contact your counselor/coach at least 24 hours in advance of your scheduled time. You may call any time of day or night and leave a confidential voice mail message. Failure to do so will result in you being charged the full professional service fee, payable on your next visit. Advance cancellations allow us to make the most efficient use of time and office space.

NO SHOWS

If you fail to show up for an appointment and have not notified your counselor/coach at least 24 hours in advance, you will be considered to have been a "no-show." It is your responsibility to contact your counselor/coach before your next session to confirm your next appointment by leaving a message on his/her voice mail. You will be expected to pay for the "no show" session.

CONTACTING YOUR COUNSELOR

You may leave a confidential voice mail message for your Living Water Christian counselor or coach by using the phone number provided below.

- | | |
|---|-----------------------|
| <input type="checkbox"/> Debbie Miller, M.A., LMHC
Licensed Mental Health Counselor #LMHC 9860 | (407) 342-3559 (cell) |
| <input type="checkbox"/> Amy Roza, M.A.
Registered Mental Health Counselor Intern #IMH6292 | (407) 756-6181 (cell) |
| <input type="checkbox"/> Denise Kirsop, M.A.
Registered Mental Health Counselor Intern # | (407) 948-9462 (cell) |
| <input type="checkbox"/> Betsy Kleiman, M.A.
Career and Life Coach | (407) 376-8522 (cell) |

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 regarding our Privacy Practices, please contact:

Debbie Miller, LMHC
Church of the Ascension
4950 S. Apopka-Vineland Road
Orlando, FL 32819
(407) 876-3593

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, _____
(Full Name, please print)

have received a copy of Living Water Christian Counseling's Notice of Privacy Practices. Living Water Christian Counseling is a ministry of Church of the Ascension.

Name: _____

Street Address: _____ Ste/Apt _____

City: _____ State: _____

Zip Code: _____

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____