Wilson Counseling
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PERMISSIONS AND CONSENTS

See **FOR YOUR RECORDS** form for corresponding information

Client Name: _____

1. **ASSIGNMENT OF BENEFITS** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

2. **PRACTICE POLICIES AGREEMENT** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

3. **PERMISSION TO TREAT FOR MYSELF** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

4. **CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION** (All clients MUST sign)

_____ _____
Signature of Client or Guardian Date

5. **SESSION RECORDING POLICY** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

6. **CLIENT TEXTING/EMAIL CONSENT** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

7. **PERMISSION TO TREAT FOR MY CHILD. IF JOINT CUSTODY BOTH PARENTS MUST SIGN!**

_____ _____
Signature of Parent 1 Date

_____ _____
Signature of Parent 2 Date

8. **PERMISSION TO TREAT VIA TELEHEALTH** (All clients **MUST** sign)

_____ _____
Signature of Client or Guardian Date

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INTAKE PACKET

NEW ☐ **UPDATED** ☐ **THERAPIST:** _____

Client Name: _____ Today's Date: _____

Responsible Party (if different) & Relationship: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ or _____ SSN: _____

Date of Birth: _____ _____ Age Gender: ☐ Male ☐ Female ☐ Other

Emergency contact/Relationship and phone number: _____

Health Insurance Provider: _____

Who referred you to Wilson Counseling/Wilson Place? _____

Assessment requested by: ☐ Self ☐ Court ☐ Attorney ☐ DCBS ☐ Other

Please give a brief description of problem.

_____

_____

_____

_____

_____

_____

Length of problem: _____ (months/years) Problem severity: ☐ Serious ☐ Moderate ☐ Minor

Please check current or recent symptoms:

☐ Abuse (physical)	☐ Excessive Energy	☐ Panic Symptoms
☐ Abuse (sexual)	☐ Financial Stress	☐ Overreact often
☐ Abuse (emotional)	☐ Focus problems	☐ Opposition or Disrespectful
☐ Anxiety	☐ Grief	☐ Relationship Problems
☐ Depressed mood	☐ Hallucinations	☐ Self-harm thoughts
☐ Dislike of self	☐ Impulsive Behavior	☐ Sleep Problems
☐ Divorce/Separation	☐ Irritability	☐ Suicidal Thoughts
☐ Eating Problem	☐ Loss of Interest	☐ Suspiciousness
☐ Excessive Anger	☐ Memory Problems	

If you have experienced suicidal thoughts or have previous attempts, when? _____

Previous Mental Health Services

Name of Provider_____ Inpatient ☐ Outpatient ☐ Year _____

Reason/Diagnosis _____

Name of Provider_____ Inpatient ☐ Outpatient ☐ Year _____

Reason/Diagnosis _____

Please list person who live with you.

Name	Relationship	Age	How you get along
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list supportive person in your life (friends or family).

Name	Relationship	Age	How you get along
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your parents separated or divorced, how old were you? _____

Did you have any problems in utero, infancy, or early childhood? _____

How would you describe your childhood? ☐ Very pleasant ☐ Pleasant ☐ Difficult ☐ Very difficult

CLIENT NAME: _____

Family history of mental health issues

☐ None ☐ Depression ☐ Anxiety ☐ Alcohol/Drugs ☐ Other

Father _____

Mother _____

Siblings _____

Father's Family _____

Mother's Family _____

Health (Please check conditions you have experienced)

☐ AIDS	☐ Seizures	☐ Tics
☐ Diabetes	☐ Allergies	☐ STDs
☐ Liver Disease	☐ Hospitalization	☐ None
☐ Headaches	☐ Asthma	Other _____
☐ Heart Disease	☐ Cancer	Other_____

Please list any drug or food allergies.

_____

Please list all medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Who prescribes the mediation? _____

Who is your current Primary Care Provider? _____

Permission to release information to you Primary Care Provider? ☐ Yes ☐ No

Cultural Preferences

Faith-based beliefs: _____ Ethnicity: _____

Educational History

Are you currently a student? Yes ☐ No ☐ School _____ Grade _____

Did you have learning difficulties? Yes ☐ No ☐ Behavior problems at school? Yes ☐ No ☐

How much do you enjoy school? A lot ☐ Some ☐ Little ☐ None ☐

CLIENT NAME: _____

Work History

Are you currently employed? Yes ☐ No ☐ If yes, where? _____ How long? _____

Employer phone number? _____

How much do you like your job? A lot ☐ Some ☐ Little ☐ None ☐

Alcohol/Substances

Alcohol use: Several drinks daily ☐ Several drinks weekly ☐ A few drinks a month ☐ None ☐

Substance use: Currently use ☐ Used in Past ☐ Never used ☐

Legal History

Do you have an active court case? Yes ☐ No ☐ Court/Judge: _____

Do you have another court date? Yes ☐ No ☐ If yes, when? _____

Do you have an open DCBS case? Yes ☐ No ☐ If yes, worker: _____

Have you ever been the perpetrator of abuse? If yes, when? _____

Social History

How many friends do you have? None ☐ Few ☐ Some ☐ Many ☐ A lot ☐

What are your interests or hobbies? _____

What are your strengths or things you like about yourself? _____

What are things you want to change about yourself? _____

Are you currently participating in any of the following community services?

Family Enrichment Center ☐ Child Advocacy Center ☐ BRASS ☐

DCBS ☐ Hope Harbor ☐ Other ☐

CLIENT NAME: _____

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TARGETED CASE MANAGEMENT SCREENING

Complete TCM Screening Tool if 4 or more are checked

What areas of your life do you need resources or guidance to increase your overall well-being? (circle all that apply)

Housing Health Employment Legal Relational Nutrition/Food Transportation Education

1. Do you have Medicaid?
- ☐ Yes
- ☐ No

2. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
- ☐ Yes
- ☐ No

3. Within the past 6 months, you worried that your food would run out before you got money to buy more.
- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

4. Within the past 6 months, the food you bought just didn't last and you didn't have the money to buy more.
- ☐ Yes
- ☐ No

5. Do you put off or neglect going to the doctor because of distance or transportation?
- ☐ Yes
- ☐ No

6. In the past 6 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- ☐ Yes
- ☐ No

7. Do problems with child care make it difficult for you to work or study?
- ☐ Yes
- ☐ No

8. Do you have a job?
- ☐ Yes
- ☐ No

9. Do you have a high school degree/GED?
- ☐ Yes
- ☐ No

10. How often does this describe you? I don't have enough money to pay my bills:
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

11. Would you like help with any of these needs?
- ☐ Medical care
- ☐ Dental care
- ☐ Vision care
- ☐ Psychiatric care
- ☐ Referral for providers

12. Do you have involvement with DCBS or court?
- ☐ Yes
- ☐ No