DEANNE DIETZ, LMHC, NCC

Intake

Please return your completed intake form to set up your first appointment.
Do not drop it in the mail slot or mailbox of the office. This is a shared entrance and not secure delivery.

Name: _____ Today's date: _____

Referred by:

☐ Self ☐ Friend ☐ Family Member ☐ Other: _____

Birth Date: _____ Age: _____ Gender:

☐ Male ☐ Female ☐ Other (specify: _____)

Marital Status:

☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:

Street Number/PO Box _____ Street _____ City _____ State _____ ZIP _____

Home Phone: _____ May I leave a msg? ☐ Yes ☐ No

Other Phone: _____ May I leave a msg? ☐ Yes ☐ No This is my: ☐ Cell phone ☐ Work phone

E-mail: _____ May I email you? *Please be aware that email may not be confidential. ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

Please read the Disclosure form:

This signed statement conveys that you understand and consent to the Health Care Provider Disclosure and Notice of Privacy Practices and gives consent to therapy sessions.

Client Name (print) _____ Client Signature _____ Date _____

☐ I am 18 years or older.

I am seeking: (underline one) **Traditional Hourly Telehealth** **EMDR Intensives**

Thank you for taking the time to carefully consider these questions.
Our work together is a collaboration and it is helpful to have this information to better understand your life experiences, and current situation.

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Thank you for choosing me as your Transformation Coach or Therapist.

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish relief from right now. (you will fill out more complete assessment forms during our intake process)

2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number):

Not Intense ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Extremely Intense

3. PROBLEM DURATION: Approximately how long have you had the current problem?

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

5. SELF-SOOTHING: What strategies do you have that are calming/quieting/soothing to you?

☐ Calm place mediation ☐ Healing Light Stream through your body ☐ Squeeze/Release Muscles

☐ Deep Breathing ☐ Put worries in a Container/Box ☐ Family/Friends/People Support

☐ Body Scan (thoughts, emotions, body sensations)

☐ Other: _____

Where do you work? _____

Do you enjoy it? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No

Are you currently or formally in the military?

☐ Yes ☐ No

Are you currently receiving psychiatric services, professional counseling or psychotherapy?

☐ Yes ☐ No

CULTURAL BACKGROUND

1. What is your ethnic identity?

2. How much do you identify with your ethnic heritage? (Check one):

☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Strongly

3. Religious preference:

Are your currently active in your religion?

☐ Yes ☐ Somewhat ☐ No

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FAMILY BACKGROUND

1. Please list the **members** of your family of origin (who you lived with growing up):

2. Please check any past, present, or impending problems you have experienced:
Please specify family member(s), which problem (list below), and approximate year of occurrence (Ex. mother-serious illness, 1998)

☐ Ex deaths ☐ Divorce ☐ Frequent relocations ☐ Debilitating injuries/disabilities
☐ Alcohol/drug abuse ☐ Serious illness ☐ Psychiatric disorder neglect/emotional/physical/sexual abuse
☐ Legal ☐ Eating disorders ☐ Financial crisis/unemployment ☐ Attempted/completed suicide

3. Have you personally experienced family abuse?
☐ None ☐ Neglect ☐ Emotional ☐ Physical ☐ Sexual ☐ Unsure

4. Have you personally experienced legal problems?
☐ No ☐ Yes

5. Did you experience learning problems in elementary, middle, or high school? (Circle one):
☐ None ☐ Little ☐ Some ☐ Substantial ☐ Constant Struggle

6. In general, how happy or adjusted were you growing up? (Circle one):
☐ Poor ☐ Unsatisfactory ☐ About average ☐ Substantially ☐ Completely

7. How much is your immediate family a source of emotional support for you currently? (Circle one):
☐ None ☐ Little ☐ Somewhat ☐ Substantial ☐ Very Strong

8. How much conflict in values do you currently experience with your parents/immediate family? (Circle one):
☐ None ☐ Little ☐ Some ☐ Moderate ☐ Strong ☐ Extreme

9. Who in your family do you currently feel closest to?

Most distant from?

In most conflict with?

10. Do you feel bad about yourself, or that you are a failure, or have let yourself or your family down?
☐ Not at all ☐ Several days per week ☐ More than half the time ☐ Nearly every day

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HEALTH AND SOCIAL ISSUES

Who is your Primary Care Physician/Psychiatrist/ARNP?

_____

1. How is your physical health at present?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, Diabetes, etc.):

_____

3. Are you presently taking any prescribed medication?

If Yes: Name/Dosage: _____

For what purpose: _____

Who is prescribing? _____

If No: Have you previously been prescribed psychiatric medication?

☐ Yes ☐ No If yes, how long have you been off? _____

4. Are you having any problems with your sleep habits? ☐ Yes ☐ No (If yes, circle below)

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Feel tired frequently

☐ Other: _____

5. Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No (If yes, circle below)

☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting ☐ Significant weight change (last 2 months)

6. Do you worry about your weight or how you look?

☐ Not bothered ☐ Bothered a little ☐ Bothered a lot

7. Do you regularly use alcohol? ☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

Do you consider your alcohol consumption a problem? ☐ Yes ☐ No ☐ Unsure

8. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you consider this drug use a problem? ☐ Yes ☐ No ☐ Unsure

9. Do you have any problems or worries about sexual functioning? ☐ Yes ☐ No (If yes, circle below)

☐ Lack of desire ☐ Performance problem ☐ Sexual impulsiveness

☐ Difficulties maintaining arousal ☐ Little or no pleasure during sex ☐ Worried about sexually transmitted disease

☐ Other: _____

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10. How many times per week do you exercise?_____ For about how long each time? _____

11. Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

☐ Frequently ☐ A few times ☐ Once ☐ Never ☐ Unsure If so, how old were you? _____

12. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

13. Have you ever intentionally inflicted any harm upon yourself? ☐ Yes ☐ No ☐ Unsure

14. In the past, how would you rate the quality of your peer relationships?

☐ Very Poor ☐ Unsatisfactory ☐ About Average ☐ Good ☐ Excellent

15. In the last 6 months, how would you rate the quality of your peer relationships?

☐ Very Poor ☐ Unsatisfactory ☐ About Average ☐ Good ☐ Excellent

16. Approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved in? _____

Are you in one now? ☐ Yes ☐ No ☐ I think so

17. Besides family members, who can you really count on right now for friendship or emotional support?

_____

Option 1: Individual or Couples:

Self Pay Agreement: not charted to medical necessity/does not qualify for insurance reimbursement

I attest that I :

a.) do not have insurance coverage, or

b.) have insurance coverage but choose not to use it, and understand that in doing so I waive my right to reimbursement, or

c.) have insurance coverage, but understand this is not a covered service.

I understand the Self Pay Agreement.

Signature _____ Printed Name _____ Date _____

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Option 2: For Individual Intake or First Hour of Intensive Sessions Only:

- **If you would like me to assist you in getting reimbursement from your insurance company, complete all of the information below (even if it is also on Page 1).**
- **A copy of your Insurance Card and picture ID is due at your first appointment. If we are doing telehealth, please send a copy of the front and back of your Insurance Card and picture ID prior to your appointment.**
- **Payment is due via Venmo or Paypal within 24 hours to confirm your appointment. I will provide you with a superbill after your appointment to use as your receipt on your reimbursement claim.**
- **I do not bill Medicare. You will not receive reimburse for services with a superbill.**

Insurance Company Name _____ Insured's ID Number -include prefix _____ Group Number _____

Plan Name _____ Eligibility/Provider/Behavioral Health Phone Number _____

Policy Holder's Legal Name _____ Policy Holder's Phone Number _____ Policy Holder's Date of Birth _____

Policy Holder's Full Mailing Address

Street Number/PO Box _____ Street _____ City _____ State _____ ZIP _____

Policy Holder's Employer _____ Patient's Legal Name- if different than policy holder _____

Patient's Telephone- if different than policy holder _____ Patient's Date of Birth _____ Patient's relationship to policy holder ☐ Spouse ☐ Child ☐ Other

Patient's Full Mailing Address- if different than policy holder

Street Number/PO Box _____ Street _____ City _____ State _____ ZIP _____

Is the condition related to employment? ☐ Yes ☐ No

Is this condition related to an accident? ☐ Yes ☐ No

It is my understanding that this release of information to my insurance company can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.

I understand that Heart Healing Counseling Corporation will submit my claim to my insurance as a courtesy and I am responsible for paying my balance due.

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of signature. **All of this requested information is due prior to scheduling your first appointment.**

Signature (client / parent / guardian / legal representative for healthcare decisions) _____ Date _____