WEST TEXAS COUNSELING & GUIDANCE

Date: _____

Adult Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred you?_____ Why did they refer you?_____

Why did you choose WTCG over other options?_____

What would you like to see happen as a result of counseling?_____

Did something happen to prompt you to seek help now, versus when the problem first began?_____

_____

Are you seeking disability due to your current mental/emotional health? ☐ Y ☐ N

Are you seeking counseling due to a court order or criminal charges? ☐ Y ☐ N

Client Information

Last Name_____ First Name_____ Middle Initial____

Birth Date_____ /_____ /_____ Social Security Number_____-_____-_____

Street Address_____ Apt #_____

City_____ State_____ Zip_____ Home phone_____

Cell phone_____ Email_____

May we: ☐ Call ☐ Leave a message ☐ Text ☐ None Prefer: ☐ Cell ☐ Home

Gender
- ☐ Male
- ☐ Female
- ☐ Non-binary/3rd gender
- ☐ Prefer to self-describe _____
- ☐ Prefer not to say

Sexual Orientation
- ☐ Straight/Heterosexual
- ☐ Gay, Lesbian, or Queer
- ☐ Bisexual
- ☐ Prefer to self-describe _____
- ☐ Prefer not to say

Do you identify as transgender?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Relationship status: ☐ Single ☐ Significant other ☐ Cohabitating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, how long?_____ If divorced/widowed, when?_____

Racial/Ethnic identity: ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ White/Caucasian ☐ Other_____

Emergency Contact: Name_____ Contact number_____

Relationship to the client_____

Military: ☐ Active Duty ☐ National Guard/Reserves ☐ Prior Service ☐ Retired ☐ Dependent
☐ Medically Separated ☐ Service Connected Disability ☐ Combat Veteran
☐ Branch_____ Dates of Service_____

Education: Highest Level of Education Completed
☐ GED ☐ High School ☐ Grade _____ ☐ Some College ☐ Associate's Degree
☐ Bachelor's Degree ☐ Graduate Degree ☐ Professional Certification

☐ Current Student School_____ Studying_____

☐ Other_____

Employment: ☐ Full-Time ☐ Self-Employed ☐ Part-Time ☐ Homemaker
☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Employer_____

What type of work do you do?_____

Family:

Parents Mother Living (age) _____ Deceased (date) _____

Father Living (age) _____ Deceased (date) _____

Siblings How many?_____ I am the: ☐ Oldest ☐ In the Middle ☐ Youngest ☐ Only Child

Names and ages of your children_____

Names and ages of step-children_____

Who lives at home with you?_____

Have any of your children died? ☐ Y ☐ N if yes, please provide details_____

What do you consider the most significant events in your life?_____

Have you or anyone in your family experienced domestic violence or abuse? ☐ Y ☐ N

Are you currently experiencing domestic violence or abuse? ☐ Y ☐ N

Religion/Denominational preference_____ Congregation (if any _____

Medical History of Client

Primary Physician_____ Date of last medical examination_____

List any physical illness or symptoms you are having at this time_____

List major surgeries or illnesses in the last five years_____

List current medications (include dosages and physician prescribing)_____

Check all that you have experienced in the last month

☐ Thoughts of suicide	☐ Anxiety	☐ Rage
☐ Thoughts of death	☐ Excessive worry	☐ Anger
☐ Plans to harm self	☐ Panic Attacks	☐ Irritability
☐ Thoughts of harming others	☐ Chronic fear	☐ Relationship to significant other
☐ Plans to harming others	☐ Irrational fears	☐ Relationship to parents
☐ Self-injury	☐ Problems due to abuse/trauma	☐ Relationship to children
☐ Loss of meaning in life	☐ Stress	☐ Sexual problems
☐ Loss of hope	☐ Obsessions	☐ Sexual orientation
☐ Depression	☐ compulsions	☐ Gender identity issues
☐ Decreased pleasure	☐ Phobias	☐ Conflicts at work
☐ Lack of activities	☐ Feel like I'm losing control	☐ Problems in school
☐ Isolating/withdrawn	☐ Restlessness	☐ Loss of faith in God
☐ Decreased energy/fatigue	☐ Muscle tension	☐ Religious doubts
☐ Change in appetite	☐ Problems with sleep	☐ Substance use problems
☐ Significant weight change	☐ Problems with concentration	☐ Hallucinations
☐ Feelings of worthlessness	☐ Problems with memory	☐ Delusions
☐ Grief	☐ Avoid open spaces	☐ Easily distracted
☐ Loneliness	☐ Behavioral problems	☐ Other/Explain below
☐ Guilt feelings	☐ ADHD	

What else are you experiencing at this time?_____

Mental Health History

Have you experienced mental health problems before? ☐ Y ☐ N If yes, explain_____

Do you have a family history of mental health problems? ☐ Y ☐ N

Have you ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

☐ Y ☐ N If yes, when and where?_____

Have you ever been hospitalized or received inpatient treatment for mental health issues? ☐ Y ☐ N If yes, when and where?_____

Self-Harm

Have you wished you were dead or wished you could go to sleep and not wake up? ☐ Y ☐ N

Have you had any actual thoughts of killing yourself? ☐ Y ☐ N

Have you ever attempted suicide? ☐ Y ☐ N If yes, number of attempts_____

Have you ever lost someone you care about to suicide? ☐ Y ☐ N

If yes, who and when?_____

Substance Use History

Do you drink alcohol? ☐ Y ☐ N On average, how many drinks do you have?_____ per _____
quantity & type *day/week/month*

Do you use drugs (illegal drugs, recreational drugs, drugs not prescribed to you or used in excess of how they are prescribed)? ☐ Y ☐ N If yes, which ones?_____

How often?_____ per_____ IV drug use? ☐ Y ☐ N
quantity & drug *day/week/month*

Have you ever received outpatient treatment (counseling, therapy, psychiatrist, or medication) for a drug or alcohol problem? ☐ Y ☐ N If yes, when and where?_____

Completed successfully? ☐ Y ☐ N

Have you ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

☐ Y ☐ N If yes, when and where?_____

_____ Completed successfully? ☐ Y ☐ N

What other information is it important for your therapist to know?_____

_____

_____

Acknowledgement

The information written on this form is accurate, to the best of my knowledge.

_____ _____
Signature of Client Date

WEST TEXAS
COUNSELING & GUIDANCE

Appointment Reminder Preference

Client Name: _____

West Texas Counseling & Guidance utilizes a contracted service to provide automated reminders of your next appointment 24 – 48 hours in advance as a courtesy reminder. Please choose a reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

_____ _____
Signature of Client Date

_____ _____
Signature of WTCG Staff Date

WEST TEXAS COUNSELING & GUIDANCE

No Shows and Cancellations

Client Name: _____

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. If you fail to give 24 hours notice before cancelling their appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to make same-day appointments with your counselors. Clients may also be charged a **$25 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than $25 per session, the fee will be your usual session charge. Clients with certain insurances cannot be billed the missed appointment fee- Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

Counselor Discretion: The counselor may choose to continue to see the client without requiring same-day appointments. The counselor may also waive the $25 fee.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation.

Due to the counselors maintaining a set schedule:

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

By signing this agreement I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

_____ _____
Signature of Client Date

_____ _____
Signature of WTCG Staff Date

WEST TEXAS COUNSELING & GUIDANCE

Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction.

I am making an informed decision, free of any coercion, to engage in psychotherapeutic/counseling/clinical social work services. It is my right to terminate these services at any point.

_____ _____
Signature of Client Date

_____ _____
Signature of WTCG Staff Date

Patient Health Questionnaire- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	*0* + ____	+ ____	+ ____	+ ____

=Total Score: ____

If you circled <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?

(Circle your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

☐ yes ☐ no

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   ☐ yes ☐ no

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   ☐ yes ☐ no

3. been constantly on guard, watchful, or easily startled?

   ☐ yes ☐ no

4. felt numb or detached from people, activities, or your surroundings?

   ☐ yes ☐ no

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   ☐ yes ☐ no

For office coding- Total: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		

	In the Past 3 Months	
6) ***Have you done any of the following?*** ***<u>Attempted to kill yourself even if ending your life was only part of your motivation</u>*** ***<u>Started to do something to end your life but someone or something stopped you before you actually did anything</u>***		
<u>Started to do something to end your life but you stopped yourself before you actually did anything</u> ***<u>Taken any steps towards making a suicide attempt or preparing to kill yourself</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***In your entire lifetime, how many times have you done any of these things?***		

WEST TEXAS COUNSELING & GUIDANCE
VETERANS OUTREACH SERVICES

Date: _____

Military Program Eligibility Form

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's First Name_____ Last Name _____ Middle Initial ____

Birth Date: ____ /____ /____ Last 4 of SSN _____ Gender: ☐ M ☐ F Phone: _____

1. Has the client ever served in the U.S. Military? ☐ Y ☐ N (if *no*, skip to question 2)
   a. **If *yes*,** what branch do/did you serve in?
      - ☐ Army
      - ☐ Air Force
      - ☐ Navy
      - ☐ Marine Corps
      - ☐ Coast Guard

   b. What is your current military status?
      - ☐ Active duty
      - ☐ Retired
      - ☐ Prior service/inactive
      - ☐ Medically separated/retired
      - ☐ National Guard/Reserves

   c. Dates of service: from _____ to_____
   d. Client receives services from the V.A. ☐ Y ☐ N
   e. Client has a service connected disability ☐ Y ☐ N Rating _____%
   f. Client is a combat veteran ☐ Y ☐ N Name of operation/conflict:_____

2. Is the client a current dependent of a U.S. active duty or retired service member? ☐ Y ☐ N

3. Is the client related to any of the following who have ever served/or are currently in the U.S. military? ☐ Y ☐ N
   ☐ Spouse ☐ Fiancé ☐ Boyfriend/girlfriend ☐ Son/daughter ☐ Sibling ☐ Parent

ⓘ **If you answered no to 1-3, you do not have to continue this form.**

4. If you answered yes to either 2 or 3, please answer the following:
   a. Name of service member:_____
   b. What branch does/did they serve in?
      - ☐ Army
      - ☐ Air Force
      - ☐ Navy
      - ☐ Marine Corps
      - ☐ Coast Guard

   c. What is their current military status?
      - ☐ Active duty
      - ☐ Retired Prior service/inactive
      - ☐ Medically separated/retired
      - ☐ National Guard/Reserves

   d. Dates of service: from _____ to_____

In order to satisfy grant requirements, we need to verify eligibility via DD-214, ID, orders, or some other way to demonstrate military service.

WEST TEXAS COUNSELING & GUIDANCE
VETERANS OUTREACH SERVICES

Eligibility of military or dependent status established by following documentation

Each individual seeking services needs to verify eligibility as either a service member or a qualified family member. Please see example of documents below needed to verify eligibility. If individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding this program.

- ☐ military issued ID
- ☐ VA ID
- ☐ state issued veteran ID card (for the service member or a dependent)

All of the following require some form of photo ID

- ☐ DD 214
- ☐ birth certificate
- ☐ marriage certificate
- ☐ ID.me wallet- https://www.id.me/
- ☐ Signed statement by service member of familial relation

Other documents that can be used to verify military service (+ photo ID):

- ☐ orders of separation/retirement
- ☐ LES (Leave and Earning Statement)
- ☐ W2 reflecting military service
- ☐ orders of promotion
- ☐ orders of TDY (temporary duty)
- ☐ orders of PCS (Permanent Change of Station)
- ☐ orders to attend a military school
- ☐ orders of deployment
- ☐ citations from military awards, medals and decorations
- ☐ certificates of completion of a military school or operation
- ☐ DD form 4- Enlistment/Reenlistment Documents
- ☐ an award letter of benefits from the VA
- ☐ verification from a government program of the individual's veteran status
- ☐ military medical/dental records
- ☐ a sworn statement from veteran's military commander
- ☐ any other method likely to ensure legitimate eligibility of veteran or family member

ⓘ Individuals requesting services and claiming eligibility without written documentation of eligibility will be granted presumptive eligibility for a reasonable time of no longer than 30 days. This allows the veteran or family member to acquire the DD 214 (per the National Archives, 92% of requests for DD214 receive a response within 10 days), plus, additional time to obtain necessary documentation and other ID to establish eligibility. During the presumptive eligibility period, services provided will be those services and referrals necessary to assist the veteran or family member in establishing eligibility for services of the program, or other programs, as well as any indicated crisis services (services necessary to prevent injury from suicide, injury to others, substance use disorders, etc.).

- ☐ **Copy of eligibility documents provided and included in chart by WTCG staff signing below**
- ☐ **Eligibility documents visually verified by WTCG staff signing below**

_____ _____

WTCG Staff Date