Individual Adult Intake Form
Mount Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

Welcome! Please provide the following information as completely as you can. The information provided here is protected as confidential information.

Name: _____ **Date of Birth**_____**Age: _____Today's Date:_____**
Address: _____ **City**_____
State/Zip _____
Preferred Phone: _____ May we leave a message? ____ yes __ no
Secondary phone:_____ May we leave a message? ____ yes __ no

Email: _____ May we leave a message? ___ yes ___ no

Emergency Contact Person_____ Phone_____

Relationship?_____ Permission to contact? Yes _____ No _____

Your Occupation: _____ Your Employer: _____

If currently a student, please list school, field of study, and degree toward which you are working:
_____

Are you a Member of Mt. Olivet Church? Yes [ ] No [ ] How did you hear about the Counseling Service?_____

Have you previously seen a counselor at the Counseling Service? [ ] Yes [ ] No If so, when?_____

Gender: [ ] Female [ ] Male [ ] Transgender [ ] Non-binary [ ] Other.
Preferred Pronouns [ ] She/her/hers [ ] He, him, his [ ]They/them/their

Your Relationship Status:
( ) Single
( ) Long term relationship for _____ years
( ) Married for _____ years
( ) Separated after a marriage of _____ years
( ) Divorced for _____ years after a marriage of _____ years
( ) Remarried for _____ years
( ) Widowed after a marriage of _____years
Your Spouse/Partner's name if applicable: _____ Age:___Occupation:
_____

Your Family Information
First name, date of birth, and age of any children or step-children or other dependents you have:
1)_____ d.o.b_____ age:__ 2) _____ d.ob. ____ age: __ 3)_____
d.o.b._____ age: __ 4)_____ d.o.b_____ 5)_____ d.ob. ____ age: ____
6)_____ d.o.b._____ 7) _____ d.o.b. _____ age ____
Are there any co-parents or step-parents involved in your children's care? ( ) Yes ( ) No
If yes, their names: _____
With whom do you live?: _____
Your Family of Origin Information:
Father's name _____ Alive? _____ Age:____ Occupation: _____

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Mother's name _____ Alive? _____ Age: ____ Occupation: _____
What is/was your parent's marital status? ( ) married ( ) divorced ( ) separated
( ) father remarried ( ) mother remarried ( ) parents never married
First name, age, and gender of any siblings and stepsiblings you have: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult

Name: _____ Age: ____ **Date:_____**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem **during the past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day.	
I	**1. Little interest or pleasure in doing things?**	**0**	**1**	**2**	**3**	**4**	
	2. Feeling down, depressed, or hopeless?	**0**	**1**	**2**	**3**	**4**	
II	**3. Feeling more irritated, grouchy, or angry than usual?**	**0**	**1**	**2**	**3**	**4**	
III	**4. Sleeping less than usual, but still have a lot of energy?**	**0**	**1**	**2**	**3**	**4**	
	5. Starting lots more projects than usual or doing more risky things than usual?	**0**	**1**	**2**	**3**	**4**	
IV	**6. Feeling nervous, anxious, frightened, worried or on edge?**	**0**	**1**	**2**	**3**	**4**	
	7. Feeling panic or being frightened?	**0**	**1**	**2**	**3**	**4**	
	8. Avoiding situations that make you anxious?	**0**	**1**	**2**	**3**	**4**	
V	**9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs?)**	**0**	**1**	**2**	**3**	**4**	
	10. Feeling that your illnesses are not being taken seriously enough?	**0**	**1**	**2**	**3**	**4**	
VI	**11. Thoughts of actually hurting yourself?**	**0**	**1**	**2**	**3**	**4**	
VII	**12. Hearing things other people couldn't hear, such as voice even when on one was around?**	**0**	**1**	**2**	**3**	**4**	
	13. Feeling that someone could hear your thoughts, or that you could what another person was thinking?	**0**	**1**	**2**	**3**	**4**	
VIII	**14. Problems with sleep that affected your sleep quality over all?**	**0**	**1**	**2**	**3**	**4**	
IX	**15. Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?**	**0**	**1**	**2**	**3**	**4**	
X	**16. Unpleasant thoughts, urges or images that repeatedly enter your mind?**	**0**	**1**	**2**	**3**	**4**	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	**0**	**1**	**2**	**3**	**4**	
XI	**18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?**	**0**	**1**	**2**	**3**	**4**	
XII	**19. Not knowing who you really are or what you want out of life?**	**0**	**1**	**2**	**3**	**4**	

	20. Not feeling close to other people or enjoying your relationships with them?	**0**	**1**	**2**	**3**	**4**	
XIII	**21. Drinking at least 4 drinks of any kind of alcohol in a single day?**	**0**	**1**	**2**	**3**	**4**	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	**0**	**1**	**2**	**3**	**4**	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g. painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquillizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue) or methamphetamine (like speed)?	**0**	**1**	**2**	**3**	**4**	

Mental Health History:

Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no

If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
_____	_____	_____
_____	_____	_____
_____	_____	_____

What did you find most helpful in therapy?

_____

__

What did you find least helpful in therapy?

_____

Please list any current or chronic mental health issues/diagnoses for yourself:

Issue: _____ Medications? _____ For how long? _____

Issue: _____ Medications? _____ For how long? _____

Most recent evaluation of your mental health medication prescriptions? Date: _____

Have you ever been hospitalized for psychiatric reasons? ( ) yes ( ) no

Is there a history of mental illness in your family? ( ) yes ( ) no

If yes, please elaborate _____

_____

Have you ever had thoughts about harming yourself? ( ) Yes ( ) No

Have you ever engaged in self-harm behaviors? ( ) Yes ( ) No

If so, explain _____

Have you ever had thoughts of harming others? ( ) Yes ( ) No

Do you have any history of aggression toward others? ( ) Yes ( ) No

If yes, please explain _____

What is your **faith/spirituality history**?_____

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Medical Problems & Medication: Please list any current medical issues you are facing and medication (and dosage) you are taking: _____

_____

Hospitalizations? _____

Most Recent Physician's Physical?_____

Substance Use: Please check substances you use on a daily, weekly OR monthly basis:

( ) Alcohol How many drinks per day___, week or ___ month ____?
( ) Marijuana Use per day___ week ___ or month ____?
( ) Caffeine How many drinks per day___ week ___ or month ____?
( ) Tobacco, type: Use per day___ week ___ or month ____?
( ) Cocaine Use per day___ week ___ or month ____?
( ) Opioids Use per day___ week ___ or month ____?
( ) Amphetamine/speed Use per day___ week ___ or month ____?
( ) Other & amount used: _____

Do you believe your use may be a problem? yes ( ) no ( ) Please describe:

_____

CAGE ASSESSMENT:

Have you ever felt you needed to **C**ut down on your chemical use? yes ( ) no ( )
Have people **A**nnoyed you by criticizing your drinking? yes ( ) no ( )
Have you ever felt **G**uilty about drinking? yes ( ) no ( )
Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover? yes ( ) no ( )
Have you ever been assessed/treated for chemical related problems? yes ( ) no ( )
Any chemical-use related legal problems? yes ( ) no ( )
Family history (__grandparents, __parents, __siblings) of substance abuse? yes ( ) no ( ) Please describe:

_____

Significant Cultural History or issues you feel are important for your therapist to know:

_____

Education: Please indicate your highest education level: ( ) Less than high school ( ) High school equivalent/GED ( ) High school diploma ( ) Vocational ( ) Some college ( ) Bachelor's degree ( ) Master's degree ( ) Doctoral degree ( ) Other: _____ Major/minor/area of concentration _____

Did you experience any learning problems in school? yes ( ) no ( ) If yes, please describe: _____

_____

What do you feel are your Personal Strengths? Ie., what do you do well and what activities do you enjoy, or what personal qualities would others say you have?

_____

_____

What kinds of support systems (connections) do you have in your life? _____

_____

Current Issues: What are your areas of greatest challenge, or the areas you would like to grow or change in while attending therapy? _____

_____

_____

_____

_____

_____

_____

Financial Issues: (Please check any concerns you are currently having)
( ) Credit card debt ( ) Gambling debts ( ) mortgage foreclosure ( ) insufficient income ( ) Unemployment ( ) Student loan debt ( ) collections/unpaid bills ( ) underemployment

Legal Issues: Please list any legal issues that are affecting you or your family right now, or which have had a significant impact on you in the past? _____

_____

Concern about food/eating: Binge eating?__ Purging? __ Restricting intake? __
Describe: _____

_____

Concerns related to Sexuality:

_____

Concerns related to gender identity:_____

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Family or Relationship Concerns: (Please check any concerns you currently have)

( ) Fighting/anger
( ) Separation/divorce
( ) Sexual/Gender identity conflicts
( ) Lack of honesty
( ) Physical fights/abuse
( ) Sexual abuse
( ) Disagreement about parenting
( ) Disagreement about sexuality
( ) Mental health concerns in family
( ) Grief and Loss

( ) Disagreeing about relatives and/or friends
( ) Conflict with relatives and/or friends
( ) Alcohol use of partner or relative
( ) Drug use
( ) Other Addictions: _____
( ) Infidelity
( ) Financial issues
( ) Disagreement about role of social media
( ) Physical health concerns in family
( ) Traumatic events

( ) Emotional Abuse
( ) Blended Family issues

( ) Other:_____

Is there anything else you think would be helpful for your therapist to know?

_____

_____

_____

_____

INFORMATION FOR CLIENTS & INFORMED CONSENT FOR THERAPY

APPOINTMENTS AND SCHEDULING:

All appointments are scheduled with our Office Manager, Molly Pach, by calling 612-927-7335 or emailing mpach@mtolivetcounseling.org. Press 10 to leave her a voice mail. It is your responsibility to schedule your appointments and keep them. Please be alert to how many appointments remain in your series and discuss your scheduling options as needed with your clinician. Psychiatric consultations are scheduled one appointment at a time. **We are not a crisis center.** The telephone is answered Monday through Friday, usually prior to 12:00pm. If you are in crisis or believe a crisis may arise, please call 911. We do offer some evening appointments. Sessions are 50 minutes long. If a client is late for their appointment, the appointment time will not be adjusted.

Please contact Molly 24 hours in advance of the scheduled appointment time, if you need to cancel, so that your time can be given to someone waiting for an appointment. **A no-show, or a cancellation later than 24 hours prior to the scheduled appointment will be charged the session fee.** We reserve the right to decline scheduling of future appointments if there is a pattern of cancellations or no-shows.

FEES

Fees for members of Mount Olivet are $50.00 per session for counseling and medication management services. Fees for non-members are $100.00 per session. We do not work with third party payers/insurance companies.

We do not send out monthly bills or keep record of payments. You are asked to pay for each session as it occurs unless you make other arrangements, and to ask for a receipt if you believe you will need one.

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E-MAIL & SOCIAL NETWORKING POLICIES

If you send an email, we will generally only respond for purposes of scheduling or appointment reminders. Be aware that all e-mails are retained in the logs of your and Mt. Olivet Counseling Service's Internet service providers. While it may be unlikely that someone reads these, they are available to be read by the system administrator of the Internet service provider. You should also know that any e-mails we receive from you become a part of your legal and therapy records**. Please do not use SMS (texting), Twitter, Facebook, or LinkedIn to contact your therapist. These sites are not secure**. We do not accept friend requests or contact requests from current or former clients on any social networking site, since adding clients as friends or contacts can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please ask your therapist when you meet.

CONFIDENTIALITY:

The fact that you are a client ensures that all information about you, as well as the content of your sessions and phone conversations, will be held in strict confidence with the following possible exceptions:

- If you sign a Consent for Release of Information form, you authorize us to communicate specified information about you with one or more specified professionals or agencies outside of this office;
- In order to ensure the best possible care, the intern and professional staff meet regularly to consult and collaborate regarding client care;
- If your records are subpoenaed by signature of a judge, we are required to release them to the court; the therapist will not agree to testify in legal matters related or unrelated to therapy.
    - If you are using, mood-altering drugs including alcohol, while pregnant, we are required to report this information;
    - If you are a minor (under age 18), your parents have access to your records, unless:
        - You are emancipated, (living away from home and paying your own way) you are pregnant, or
        - You are in danger of harm from one or both of your parents;
- If you have previously had inappropriate sexual contact from any health care provider, and if you reveal the name of such provider, we are mandated to report this information to the appropriate licensing board;
- In the course of your session, if we have reason to suspect the abuse of a child or of a vulnerable adult, we are required by law to file a report of the alleged abuse to the appropriate county or state agencies. This report is required whether the alleged abuse occurs within your family or outside of it;
- In the course of your sessions, if, after careful and thoughtful consideration, we come to believe that there is a clear and imminent danger of your physically harming yourself or another person, we will take steps to prevent such potential harm, steps which will violate your confidentiality.
- Making threatening statements of harm to any Mount Olivet Counseling Service staff person or their family, will result in termination of therapy and notification of proper authorities.

PHILOSOPHY:

In most situations, the therapist's role is that of a consultant. The therapist's job is to help you think about what your problems are and explore possible solutions to your problems. The therapist will listen to you and give feedback about what they hear and what the therapist thinks your options are. Although the therapist will explore options with you, rarely will the therapist tell you what to do, because the decision and the responsibility to make changes in your life needs to be yours. Your job is to be more open and honest about yourself in therapy, than you are in social relationships and to be committed to the process of therapy. You are responsible for deciding what to talk about in each session and deciding what your goals are.

During the course of therapy, the therapist is likely to draw on various psychological approaches which stem

from the nature of the problem and the assessment of what will best benefit you. If you are not getting what you want, you have the right to ask for other treatments or for a referral to other professionals. If the therapist believes they are not being helpful to you, the therapist also has an obligation to help you find someone who might be more helpful. You may terminate treatment at any time.

Referrals: We reserve the right to refer a client to a more appropriate type of therapy with other therapists if we assess that your needs are not likely to be best served by our staff.

Referrals to our Psychiatrist or Internist at Mt. Olivet Counseling: Clients are referred to our psychiatrist or internist only internally while maintaining a counseling relationship with one of our therapists.

LEGAL WAIVER: The therapist's role is for the sole purpose of the improvement of psychological and relational distress. The process of therapy depends on trust and openness during therapy sessions. Therefore it is understood that the information given to the therapist during therapy sessions is not to be used for any legal purposes. No attempt shall be made to subpoena the therapist's testimony or records to be presented in a deposition or court hearing of any kind, for any reason such as a divorce case. **If the therapist is required to appear as a witness, the party responsible for his/her participation agrees to reimburse him/her or MTOCS at the rate of $200 per hour for the time spent traveling, preparing reports or any other case related costs.**

POSSIBLE RISKS OF THERAPY: During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, fear, or experiencing anxiety, depression, insomnia, etc. The therapist may challenge assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that could cause clients to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues in relationships may result in changes that were not originally intended. Therapy may result in the need for decisions about changing behaviors, employment, substance use, schooling, housing, or relationships, although those decisions are always the clients' to make. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. There is no guarantee that therapy will yield positive or intended results. The changes that a person may make may have an impact on other people in their lives.

INFORMED CONSENT FOR THERAPY

- I understand that therapy begins with an evaluation of my history and current concerns.
- I understand the policies described in the Information For Clients and Informed Consent for Therapy and accept them as conditions for beginning therapy with the therapist.
- I understand the Limits of Confidentiality.
- I have been given the chance to ask questions and discuss confidentiality and disclosure policies with the therapist.
- I also understand that the information discussed in therapy is for the purpose of therapy only and is not intended to be used in legal proceeding between me and others, including my partner/spouse/family members.
- I agree that the role of the therapist is to be limited to that which will therapeutically benefit my goals for therapy, and that I will not attempt to gain an advantage in any legal proceeding from my therapy.
- **I agree not to ask the therapist to testify in court, whether by person, or by affidavit, or to instruct an attorney to subpoena the therapist. I understand that this agreement may not prevent a judge from requiring the therapist's testimony, even though he/she will work to prevent such an event.**
- I agree to share responsibility with the therapist for the therapy process, including goal setting and termination.
- I understand that entering into therapy, working toward change and engaging in the process of therapy has some risks. I accept that these changes can have both positive and negative effects and agree to clarify and evaluate the potential consequences of these changes before continuing with them.

New Client – Individual Adult Counseling Intake Form

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INFORMED CONSENT FOR EVALUATION AND TREATMENT

I acknowledge that I have read and received the INFORMATION FOR CLIENTS and the policy of INFORMED CONSENT FOR THERAPY, and that I enter into therapy in agreement with this policy

Printed Name of Client _____Date _____

Signature of Client_____

***This form is valid for one year from date indicated*.**

PAYMENT AGREEMENT

I agree to pay for each session at the time of session. I will provide notification to the Counseling office prior to 24 hours before the scheduled appointment time if I need to cancel my appointment.
I understand that a **no-show, or a cancellation later than 24 hours prior to the scheduled appointment will result in my being charged the session fee.**

Signed _____ Date _____