Be Ye Renewed Counseling

INTAKE FORM

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session or email it to me as soon as possible.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Transgender
Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age:
_____

_____

Address:
(Street and Number)
_____

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell: _____ May we leave a message? □Yes □No

Work Phone: _____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if applicable):

Emergency Contact: _____Phone Number_____ Relationship_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

Primary Care Physician_____

_____
_____

2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:
In the section below please identify if there is a family history of any of the following areas. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, sibling, grandmother, uncle, etc.).

Please Circle & List Family Member

Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, name and address of your employer:

_____
_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

5. What would you like to accomplish from your time in therapy?

_____

SERVICES

Confidentiality Policy/ Consent to Treatment

The relationship you establish with Chimere G. Holmes, LPC (Psychotherapeutic counseling services) is voluntary. As a client, you have the right to end our counseling relationship at any time. All the information about you or your records is strictly confidential. Information is shared only with authorized professional staff and the persons you have listed above. Your written permission is necessary for any other instances of information to be released.

The only exceptions to this policy are as follows:

□ If there is a reason to believe that a child has been physically or sexually abused, we are required by law to report it to the state protection service. We are not making a determination that any behavior is unlawful or improper. This determination is made by the state.

□ If we have reason to believe that a client may seriously harm him/herself or another person, we are required to release information to protect the person who may be harmed.

□ If our records are subpoenaed by the court in a civil or criminal proceeding, we may be required to release the records. This situation is extremely rare and you will be notified if a subpoena is received.

□ Selected records may be made available to certifying or licensing organization for review of our recordkeeping procedures.

The following is a list of people to whom information may be conveyed:

_____

In order to protect your confidentiality, any inquiries, outside the above-mentioned exceptions (written, telephone, or personal) will NOT be answered until you sign a release of information.

I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult. **If, for any reason, you are unable to contact me by telephone (610) 235-9286, and you are having a true emergency, please call 911 or go to the nearest hospital emergency room and/or mental health crisis unit.**

You may make appointments and contact me in the following ways:
For appointments: (Hours M-F/9AM-5PM) (610) 235-9286 OR beyerenewedtherapy@gmail.com

Length of Session: A session is generally **45-60** minutes. Children sometimes will only have a 30-minute session. There is no extra charge for other individuals such as spouse, children, relatives or friends who may need to attend at your request.

Emergencies: I am generally available on a 24-hour basis. Clients, however, seen in outpatient psychotherapy are assumed to be responsible for their day-to-day functions. You may reach me in the following ways:

Office: (610) 235-9286 OR beyerenewedtherapy@gmail.com to make or cancel an appointment

I will attempt to return your call within 24 hours. This is not always possible as I may be in session with another person, speaking to a group of people or traveling from one destination to another. If a life-threatening situation arises, please go immediately to the nearest hospital Emergency Room or contact the Emergency Psychiatric services in your area.

Cancellations: The time of your scheduled appointment is reserved for you. Since the therapist's time has been reserved for you, you agree to give at least 24-hour advance notice when unable to keep an appointment. If there is less than 24-hour notice, you will be responsible for a fee of **$50.00**. **You accept financial responsibility for charges that incur during the course of the counseling services.** If at any time you are dissatisfied with counseling, please let me know as I want to grow in my ability to serve you.

Fees: **My standard rate is $110.00 for individual sessions/ $150 for couples and family therapy/ $95 for specialty consultation/ *For speaking engagements, please inquire.** Please speak openly to me about my fees. It is my desire to work with you as much as possible in promoting consistent treatment.

Fees are payable to **Chimere G. Holmes (Memo: Therapy Session). Electronic modes of acceptable payment for telehealth and therapeutic services conducted remotely during COVID-19 are via Venmo or PayPal only.**

My signature below represents my understanding of the above fee policies.

Signed:_____ Date:_____

If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the psychotherapy process.
I have read the preceding information, the therapist has also explained it to me orally, and I understand my rights as a client or as the client's responsible party.

_____ Date: _____
Client's Name (Please Print & Sign)

_____ Date: _____
Client's or Responsible Party's Signature