JULIE HONEYCUTT, LPC, LMHC, NCC
HONEYCUTT COUNSELING, LLC

Intake Registration Form

_____/_____/_____
Today's Date

_____ _____/_____/_____ _____
Name Date of Birth Age

_____ _____/_____/_____ _____
Spouse/Partner's Name (if applicable) Date of Birth Age

_____ _____ _____
Emergency Contact Name Relationship Phone

Highest level of education completed (circle one); Major_____

Jr. High GED High School 2-year college 4-year college Graduate degree

Profession/job title_____

Pending legal issues? No _____ Yes _____ If yes, what? _____

Marital Status: ▫ Single ▫ Engaged ▫ Married (number of times: _____)

▫ Separated ▫ Widowed ▫ Divorced (number of times: _____)

Client Contact Information:
To best ensure privacy and confidentiality, please list acceptable methods of contact, if messages are permitted, and the best days/times to reach you. Please indicate if the number is home, work or cell.

Phone H W C: _____ Voice Msg: Y N Days/Time: _____ Text: Y N

Phone H W C: _____ Voice Msg: Y N Days/Time: _____ Text: Y N

Mailing address: _____

City: _____ State: _____ Zip: _____

Please circle your preferred method of communication for logistical matters such as scheduling:

Text Email Phone/Voice mail Any/All

Briefly describe what brings you to initiate therapy/counseling now?/What are your goals?_____

_____

_____

Please check all topics that currently apply to your reason(s) for seeking help:

___ Anger	___ Depression	___ Anxiety	___ Suicidal thoughts
___ Loss/Grief	___ Worry	___ Finances	___ Self-injury
___ Self-esteem	___ Marital problems	___ Family problems	___ School/Education
___ Guilt/Shame	___ Apathy	___ Pornography	___ Sexual problems
___ Mood shifts	___ Health concerns	___ Job stress	___ Fear/Phobia
___ Communication	___ Sleep difficulties	___ Relationship(s)	___ Crying spells
___ Spiritual/Religious	___ Abuse history	___ Substance abuse	___ Divorce/Separation
___ Medical/Pain	___ Legal problems	___ Adjustment	___ Disordered eating
___ Obsessive thoughts	___ Body image	___ Withdrawn	___ Lying/Deceitfulness
___ Perfectionism	___ Workaholism	___ Social Anxiety	___ Legalism

___ Other (specify): _____

FAMILY: 1. current household; 2. the family in which you grew up; 3. where they currently live. Use the back of page if needed.

Name	Relationship	State/Town	Age	Gender

Please mark any issues that are currently present or have been in the past. Please include current family and the family in which you grew up. (If yes, check "previously" or "currently")

	Previously	Currently	Briefly Describe/Indicate whether in childhood or adulthood
Alcoholism			
Drug use			
Mental illness			
Domestic violence			
Verbal/Emotional abuse			
Sexual abuse			
Sexual addiction			
Divorce/Separation			
Infidelity/Affairs			
Financial problems			
Other problems			

HEALTH HISTORY: List your current healthcare provider(s), using the back of this form if necessary.
Practitioner's Name: _____
Type of Practitioner (MD, Chiropractor, Massage, OB, etc.): _____
Location: City & State:_____ Date of last visit: _____

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Health History continued: Please use the back of this page if needed.
List any and **all** diseases, illnesses, important accidents or injuries that involved surgery, hospitalization, loss of consciousness, convulsions/seizures, or diagnosis (not including pregnancies). Some examples are: heart disease, surgery, diabetes, high blood pressure, bone or joint problems, high cholesterol, arthritis, or HIV.

Illness/Injury/ Surgery	Age	Treatment received	Treated by	Result

Medications/Drugs/Supplements/Vitamins: List all you regularly take, or have taken, within the *past year*: prescribed, over-the-counter, etc. Please include tobacco, alcohol, caffeine, and marijuana products.

Medication/Drug/ Supplement	Amount	Taken for:	Prescribed and supervised by:

For women only:
Please describe any important and applicable medical information regarding: menstruation (associated pain or unusual frequency, duration, or heaviness); hysterectomy; or menopause:

_____

_____

Health habits (lifestyle):
Rate your physical activity level (1 = "little-to-none" and 5 = "very active"): _____

In what kind of physical exercise or activities do you participate? _____

_____

How often do you exercise or are physically active (average per week)? _____

How much coffee, cola, tea, or other caffeine products do you consume each day/week? _____

Do you have any problems getting enough sleep? No _____ Yes _____

How many hours do you sleep per night on average? _____

Please check any of the following sleep problems that you have experienced *within the past six months*:

___ Sleep rhythm ___ Insomnia (unable to sleep) ___ Hypersomnia (over sleeping)
___ Nightmares ___ Sleep walking ___ Narcolepsy (unexpectedly falling asleep)

Are you involved with art such as dance, painting, music, etc? No _____ Yes _____

What type of music do you listen to most often? _____

How often do you watch T.V.? _____

Which shows do you watch most often? _____

Do you enjoy reading? No _____ Yes _____ If yes, what types of material do you read?

_____

Please describe any pain issues: _____

_____

RELIGIOUS/SPIRITUAL:

Circle all phrases that describe your current religious/spiritual experience:

Atheist	*Agnostic*	*Curious*	*Seeking God*
Spiritual…not religious	*Charismatic*	*Stagnant*	*Skeptical*
Religious	*Open towards God*	*God is distant*	*Pray often*
Closed toward God	*God is cruel*	*Communal worship*	*God loves me*
Orthodox Conservative	*Liberal*	*God is good*	Numb

With what religion/denomination, if any, are you affiliated? _____
Describe your involvement with your church (Sunday school teacher, attend weekly/monthly, etc.)
_____
How long have you been attending in your current church? _____

Describe your personality: _____
_____

FINANCIAL & INSURANCE INFORMATION:
For all clients: Please fill out even if you will not be using your mental health insurance benefits.

Insurance Company:_____
Primary Insurance Carrier (you or your spouse):_____
Primary Insurance Carrier's birthdate: _____
Policy Number: _____Group #: _____

Secondary Insurance (if applicable): _____
Primary Insurance Carrier's birthdate: _____
Policy Number: _____Group #: _____

Previous Diagnosis from prior mental health care providers: _____

Self-pay and Adjusted fee clients only:
If you are self-pay (not using insurance) and you are requesting a reduced fee, please indicate your combined household income and number of dependents.
Your annual gross income $_____ Spouse's annual gross income (if applicable)
$_____
Total Combined Income $_____
Number of people living in your home: _____ Number of dependents: _____

Consent to Treatment / Therapist-Client Agreement / HIPPA Notice and Patient Rights

_____ I acknowledge that I have read the “Therapist-Client Services Agreement” and understand its content, and agree to abide by the terms therein:

I. Counseling Services Information
II. Cancellation of Appointments
III. Limits on Confidentiality
IV. Clinical Records
V. Billing, Payments, and Insurance
VI. Emergencies

_____ I acknowledge that I have been given a copy of the “Notice of Privacy Practices and Patient Rights” required by HIPPA and I understand the circumstances under which my Protected Health Information (PHI) can be disclosed.

_____ I hereby affirm that the information provided on this Intake Registration Form is complete and accurate to the best of my knowledge, and I will notify my therapist if any of the information changes.

Release of Information Authorization to Insurance Company
“I authorize Julie Honeycutt as Honeycutt Counseling, LLC to contact my insurance company in order to verify insurance benefits. I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Provider for services received.”

X_____ _____
Signature of client or Legal Guardian **Date**

Financial Responsibility Agreement
“I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my provider and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.”

X_____ _____
Signature of client or Legal Guardian **Date**

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

By signing below I indicate that I understand and agree with all of these statements.

_____ _____
Signature of client or Legal Guardian & relationship to client (if applicable) **Date**

_____
Printed name of the signer

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist **Date**