THE HOUSE OF HOPE
Phone: 715-483-3000
www.thehouseofhope3.com

Afton Location:
3411 St. Croix Trail South
Afton, MN 55001

St. Croix Falls Location:
2070 Hwy. 8
St. Croix Falls, WI 54024

Adult Intake

To best meet your needs, the information below will maximize your time here. Please allow 30-60 minutes to complete this survey prior to your first appointment. Write "N/A" for anything that does not apply.

Client Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: ____/____/____ Age: _____ Sex: _____ Martial Status: _____

Primary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Secondary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Email Address: _____ OK to Email? Yes _____ No _____

I wish to be contacted for appointment reminders via – Cell _____ Home _____ Email _____

Emergency Contact: _____ Phone #: _____

Primary Insurance: **Secondary Insurance:**

Health Plan		Health Plan	
Policy Holder		Policy Holder	
Member ID#		Member ID#	
Group/Policy #		Group/Policy #	

Responsibility Party: _____ Relationship to Client: _____

Please summarize the reasons that led you to seek our services:

_____

_____

_____

_____

_____

_____

_____

YOUR COUNSELING FOCUS
CIRCLE any problems that are significantly bothering you:

Depression	Emotional	Employment	Housing	Disability
Anxiety	Grief/Loss	Anger/Violence	Physical health	Mental health
Emotional	Health	Spiritual health	Sexuality	Relationships
Education	Finances	Legal issues	Military issues	Cultural issues
Social Life	Housing	Addiction—self	Addiction—other	Abuse
Trauma	Disability	Lifestyle	Self-harm	

Chief areas of stress during the last year:

Area	Low	Medium	High	Impact on You

You will now have the opportunity to provide more detail regarding the problems and stresses in your life. Please include any important history of each problem.

FINANCES
Describe any problems related to finances:

_____

_____

LEGAL ISSUES
Describe any problems with legal matters: (Circle) Civil / Criminal

_____

_____

_____

Are you on probation? ____ Y ____ N Give details: _____

Are you on parole? ____ Y ____ N Give details: _____

CULTURE
What is your racial or ethnic background?

Describe any problems related to race or ethnicity:

EDUCATION/EMPLOYMENT
State your completed education/training, and list the highest degree obtained, including any major:

How did you do academically? _____ Excellent _____ Good _____ Fair _____ Poor

If you are currently a student, state where, and what degree or certification you are pursuing:

Learning disabilities: _____ Y _____ N If yes, describe disability:

State your current employment and length of time there:

Please briefly summarize your work history:

Describe any problems related to school or work:

HOUSING
Do you live independently? ____ Y ____ N Type of residence: _____
Describe any threat to your housing situation: _____

MILITARY SERVICE
Which branch? _____ Active duty? ____ Y ____ N
In combat? ____ Y ____ N Where?_____
If discharged, was it "Honorable?" ____ Y ____ N Year & Rank _____
Describe any problems related to your military experience:

SPIRITUALITY/RELIGION
State any denomination, church, or group you were raised in:

State any denomination, church, or group you now attend:

How active or involved are you?

Briefly summarize your beliefs:

_____

_____

Describe any problems related to spirituality or religion:

_____

_____

SEXUALITY/REPRODUCTION

Describe any problems related to sexuality or reproduction:

_____

_____

State the year of any miscarriages: _____

State the year of any abortions: _____

FAMILY AND SIGNIFICANT RELATIONSHIPS

CURRENT marital status: (Check all that apply)

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Cohabiting _____

FORMER marital status: (Check all that apply)

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Cohabiting _____

For each marriage or serious relationship, state the name, type, time frame, and quality:

_____

_____

_____

Whom are you currently living with? Describe your family/living companions:

_____

_____

_____

List all children, step-children, or other children raised by you:

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

List anyone else for whom you are the primary caretaker: (ill, disabled)

_____

_____

You were raised by: (Describe quality of each relationship)

_____

_____

_____

_____

List all siblings, half-siblings, step-siblings, or other children with whom you were raised:

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

Name: _____ Gender: _____ Current age: _____ Related how: _____
Lived with you: Full-time ____ Part-time ____ Short-time _____ Never _____

PHYSICAL HEALTH AND MEDICAL INFORMATION:

Health concern or medical concern	Current or past	Treatment for condition	Treating doctor	Any limitations due to medical conditions

Please describe any head traumas throughout your life:

_____

_____

Please describe any significant accidents, injuries:

_____

_____

Describe any health changes in the last year:

_____

_____

How is your health overall? ____ Excellent ____ Good ____ Fair ____ Poor

List all medications you are ***CURRENTLY*** taking: (including over-the-counter)
Please include the dosage, what issue you are taking the medication for, the prescribing doctor, and how long you have been taking the medication.

_____

_____

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Treatment (Inpatient or Outpatient)	Agency/Therapist	Dates of Service	How helpful

CURRENT OR PAST CHEMICAL USE

Substance	Current or Past	Frequency and Amount	Age Started
Alcohol abuse			
Marijuana			
Cocaine			
Methamphetamine			
LSD/Mushrooms			
Heroin			
Inhalants			
Nicotine			
Other _____			
Other _____			

FAMILY HISTORY OF MENTAL HEALTH CONCERNS

Note any "blood" relatives who have or had problems with any of the following:

Check Problem		Which Family Member	Current Status
Substance Abuse			
Depression			
Bi-polar Disorder			
Schizophrenia			
Other Emotional Problems			

ASSESSMENT OF ABUSE

Abuse	Current	Past	Perpetrator, Victim, or Witness	Please describe any outside intervention such as: treatment, child protection, the legal system, etc.
Mental				
Emotional				
Spiritual				
Physical				

Please describe the nature of the abuse, when it occurred, the duration of the abuse, who was involved, and the harm it caused you or others:

_____

_____

_____

_____

SAFETY CONCERNS

Describe any risk of harm to ***SELF***:

Type of harm?

_____

Toward whom?

_____

Thoughts or actions?

_____

Past or current?

_____

Was this planned out?

_____

Describe any risk of harm to ***OTHERS***:

Type of harm?

Toward whom?

Thoughts or actions?

Past or current?

Was this planned out?

PERSONAL RESOURCES

Describe your current support system: (family, friends, church, neighbors, co-workers, etc.)

Describe your social activities, interests, and hobbies:

Describe your strengths:

What are the goals you wish to achieve during counseling?

1.

2.

3.

4.

CONSENT TO COMMUNICATE, BILL, & TREAT
(sign in front of provider at appointment)

I understand that **Gmail is NOT a secure network and is not protected by HIPAA.** Email communication and any of its attachments may contain confidential and privileged information for the exclusive use of the designated recipients (you and/or The House of Hope, including Therapists and Office Administrator/Billing).

I authorize The House of Hope to communicate with me and/or with each other regarding myself via

Email _____ (please initial) Email Address _____

Text Messages _____ (please initial) Cell Phone # _____

I authorize the release of all information that is obtained by The House of Hope to my referring doctor or funding source and I authorize payment from my funding source for services rendered to The House of Hope. I acknowledge full responsibility for payment for all costs incurred including **deductibles and co-pays and understand co-pays are due the date services are rendered.**

OR

I agree that insurance will **NOT** be billed and have opted for **Self-Pay** in the amount of $_____/per session (therapist will fill in) and acknowledge full responsibility for payment on agreed upon amount. I understand **payment is due the date services are rendered.**

I understand that I have the option to switch **Insurance Billing to Self-Pay**, or **vice versa** anytime, but if insurance has already been billed for a specific date of service(s), I am responsible for the allowable amount(s) for that date of service(s).

I understand collaboration is an important part of the treatment process and may be conducted with an appropriate signed release with, but not limited to: school guidance counselors, lawyers, teachers, doctors, child protective services, probation officers, and other mental health providers as appropriate. Effective July 15, 2017, additional services such as case summary letters, phone calls, emails, report readings, documentation for disability, guardian ad litem correspondence, and other communication or services other than direct therapy, may incur additional charges not covered by insurance and will be charged accordingly. **I agree to pay the additional charges of $50 per service and/or $100 per hour, whichever is greater, to be paid in full before services are rendered.**

I understand it is The House of Hope's policy to not testify in court regarding custody or placement of children. These situations negatively impact the therapeutic relationship and process. I understand and agree to pay **an additional fee of $500 per half day/$1000 per full day** if a House of Hope therapist has been subpoenaed or is requested to testify in court. **This fee is due in full by the requesting party on or before the day of the court appearance.**

I have read and understand the information given regarding my rights and treatment procedures. I can obtain a copy of HIPAA at any time and I understand this consent to treatment will be enforced until such time that I withdraw consent.

_____ _____

Client Signature (parent/guardian if under 18 yrs) Date

_____

Please Print Name