Kathryn Soule, PhD, LPC
4305 South Hulen St.
Fort Worth, Texas 76109

ADULT INTAKE ASSESSMENT

Client's Name: _____Date of Birth: _____ Age: _____
(mm / dd / yyyy)

Gender: M____ F____ Other _____

Preferred Name: _____Preferred gender pronoun: He ____ She ____

Ethnicity: _____ Referred by: _____

May we contact the person/agency who referred you to thank them for the referral? Yes ____ No ____

Place of Employment: _____

I consent to being contacted at the following address:

Street/Apt: _____

City/State: _____ Zip: _____

I consent to being contacted at the following phone numbers, including texting/leaving voice messages:

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Work Phone: _(_____)_____ Ext _____

I consent to being contacted at the following email address (optional)**: _____**

Note that cell phones and email cannot be guaranteed to be a confidential form of communication.

Relationship Status: Married _____ Single (never married) _____ Divorced_____ Separated_____

Widowed_____ Committed Relationship_____ Co-habitating _____ Other _____

Emergency Contact Information:

In the event of an emergency (e.g. a case where the therapist determines I may be a danger to myself or someone else), I give you permission to contact the following in addition to emergency services:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PRESENTING CONCERN:

What brings you to counseling today? _____

_____

_____

When did you first become concerned with this issue(s)?

_____

How have you attempted before now to cope and/or deal with this issue(s)?

_____

It is the policy of Soule Therapy not to discriminate against persons with regard to race, ethnicity, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, or disability.

ABOUT YOUR CONCERNS

Please mark all characteristics or areas of concern that currently apply.

❑ Abuse- specify:

_____

❑ Aggression
❑ Anger
❑ Anxiety
❑ Arguing
❑ Attention Problems
❑ Career concerns
❑ Childhood issues (your own childhood)
❑ Children-custody
❑ Choices I have made
❑ Codependence
❑ Compulsions
❑ Concentration Problems
❑ Confusion
❑ Crying
❑ Deaths
❑ Debt
❑ Decision making
❑ Dependence
❑ Depression
❑ Divorce
❑ Eating-making myself vomit
❑ Eating-overeating
❑ Eating-under-eating
❑ Emptiness
❑ Failure
❑ Fatigue
❑ Fears
❑ Financial troubles
❑ Friendship problems
❑ Gambling
❑ Grieving
❑ Guilt
❑ Health
❑ Hostility
❑ Impulsiveness
❑ Indecision
❑ Inferiority feelings
❑ Inhibitions
❑ Interpersonal conflicts
❑ Irresponsibility
❑ Irritability
❑ Judgment problems
❑ Low energy/motivation
❑ Legal matters
❑ Loneliness
❑ Loss of control
❑ Low frustration tolerance
❑ Marital conflict
❑ Marital infidelity/affairs
❑ Medical concerns
❑ Mood swings
❑ Obsessions
❑ Outbursts
❑ Oversensitive
❑ Panic or anxiety attacks
❑ Parenting
❑ Perfectionism
❑ Phobias
❑ Relationship problems
❑ Re-marriage
❑ Sadness
❑ Self harm
❑ Self-control
❑ Self-esteem
❑ Separation
❑ Sexual issues
❑ Shyness
❑ Sleep difficulties-nightmares
❑ Step parenting
❑ Stress
❑ Suicidal thoughts
❑ Violence
❑ Weight and diet issues
❑ Withdrawal, isolating

Any other characteristics?

_____

MEDICAL INFORMATION

Current Medical Problems? _____

_____

Present Medications and prescribing doctor (Names and Dosage): _____

_____

Current doctor(s)/psychiatrist(s) you have discussed any mental health concerns with (anxiety, stress, depression, related medications): _____

Have you ever had thoughts of wanting to harm/kill yourself? **Yes____ No____**

Have you ever attempted suicide? **Yes____ No____**

Do you currently have thoughts of wanting to harm yourself or someone else? **Yes____ No____**

EDUCATIONAL HISTORY

Are you currently enrolled in an education or training program? **Yes____ No____**

If yes, describe _____ Last level of education completed: _____

CURRENT HOUSEHOLD

Please list all who reside in your home on a regular or semi-regular basis.

Name	**Relationship to you**	**Age**
_____	_____	
_____	_____	
_____	_____	
_____	_____	

FAMILY OF ORIGIN INFORMATION

Name	**Relationship to you**	**Age (or age at death)**	**Year of death (if applicable)**
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		

History of abuse in family of origin? **Yes____ No____ Unsure____**

Types of abuse: Emotional____ Physical____ Sexual____ Neglect____ Unsure____

History of divorce in family of origin? **Yes____ No____** How old you were you? **_____**

History of addiction in family of origin? **Yes____ No____ Unsure____**

Person(s) _____ Type(s) of addiction **_____**

Explain any items marked Yes above: _____

_____

Significant current stressors (medical, legal, financial, work, relational, emotional, etc.): _____

_____

Please list any significant family members/friends who have died:

First Name	Role (i.e., friend, parent, brother, grandmother)	Date of Death/Age of Client

_____

_____

RELIGIOUS/SPIRITUAL HISTORY

Your religious or spiritual practice: _____

How important is religion/spirituality to you? _____

PREVIOUS TESTING OR THERAPY

Have you ever seen a mental health professional before (counselor, psychologist, psychiatrist, social worker)? **Yes____ No____** If yes, where and by whom?_____

Approximately when and for how long did you attend therapy? _____

Previous Diagnosis? **Yes____ No____** If yes, list diagnosis: _____

Any delusions or hallucinations, past or present? **Yes____ No____** If yes, describe: _____

Any substance abuse issues, past or present? **Yes____ No____** If yes, describe: _____

Did treatment include medication? **Yes____ No____** If yes, what medications did you take and for how long? _____

Have you ever been in residential treatment, inpatient psychiatric care, or hospitalized for reasons relating to suicidal ideation/attempts or mental health concerns? **Yes____ No____** If yes, please list the name of the facility, when/how long, and reason for admission: _____

_____

Effectiveness of therapy treatment: Positive _____ Negative _____ No Change _____

Reason(s) therapy was discontinued_____

Cash, checks, and credit cards are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. You will be expected to pay for late, cancelled, or missed appointments at the full rate unless you have contacted Kathryn by phone, voicemail, or email to cancel 24 hours before your scheduled appointment.

I agree to the above statements. I consent to be contacted at any of the addresses, phone numbers, and emails provided above (4 pages) through mail, email, calling, texting, or voicemails. I will immediately notify the therapist of any change. I understand that cell phones and email cannot be considered to be secure and confidential forms of communication. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

_____	_____	_____
Signature	Relationship to Client	Date

Credit Card on File Authorization (required)

Payment is due at time of service. This office requires that a credit card be kept on file in the event of any unpaid balances, late cancellations, or missed appointments. Cash, checks, and other credit cards may still be utilized at time services are rendered for payment.

Information to be completed by the card holder:

Cardholder Name: _____

Billing Address (required): _____

Email (optional, where statements may be sent): _____

I consent to the use of my credit card for appointments broken without 24-hour notice and for any unpaid fees or services: I understand that my card will be immediately charged the full fee for appointments cancelled or missed without 24-hours' notice given. I agree to receive billing statements at the email address above that include dates and types of service. I understand that email cannot be guaranteed to be a confidential form of communication. I understand that I may choose not to provide an email address for billing, and any billing statements will instead be sent to the mailing address I have provided above. I attest that I agree to this document, and all the information provided is accurate to the best of my knowledge. I further attest that I am allowed to all the rights and privileges that are associated with this card.

_____ _____

Cardholder Signature Date

_ _

Card Number: _____

Card Type: Visa MasterCard Discover AmEx

Expiration Date: _____

Print your name: _____

Kathryn Soule, PhD, LPC
4305 South Hulen St.
Fort Worth, Texas 76109

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices. The following information (6 pages) is provided to help you understand the nature of the therapeutic relationship you are entering with me, Kathryn Soule, PhD, Licensed Professional Counselor:

The Nature of Counseling

Beginning counseling means entering into a relationship for the purpose of healing. We will work together to establish goals, which may fall into the following general areas:

**Understanding conscious and unconscious motivations*
**Alleviating mental, emotional or physical symptoms*
**Resolving emotional, attitudinal, or relationship conflicts*
**Modifying feelings, attitudes, or behaviors that interfere with your functioning*

Effects of Counseling: While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your perspectives and decisions. Some of these changes could be temporarily distressing. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort, strong feelings or experiencing anxiety, depression, insomnia, etc. I ask that if you are concerned about anything you are experiencing as part of the counseling process, you please initiate a discussion with me immediately. The exact nature of changes cannot be predicted. You are responsible for any lifestyle choices or changes that may result from therapy. Together we will work toward the best possible results.

Length of Treatment: Some clients need only a few counseling sessions to achieve their goals; other may require months or even years of counseling. The number of sessions needed depends on many factors and can be discussed with me at any time. As the client, you are in complete control and may end our counseling relationship at any time, although I do ask that you participate in a final termination session.

Termination: You always have the right to refuse treatment. I reserve the right to postpone and/or terminate counseling of clients who: a) come to their session under the influence of alcohol or drugs, b) do not comply with the medication recommendations of their psychiatrist or doctor, c) do not consistently keep scheduled appointments or provide 24 hours' notice for cancellations, d) do not have an upcoming session scheduled. If at any time, I assess that you are no longer benefiting from our counseling relationship for any reason, or if an issue arises that is outside my areas of expertise, I have the right to terminate our relationship. I will attempt to discuss my assessment with you first, if possible, and will provide referrals to other mental health professionals who may fit your needs.

Nature of the relationship: The counseling relationship is a therapeutic and professional one, rather than a social or personal one. Contact is limited to scheduled sessions times and scheduling between sessions. If more support is required, you may choose to schedule additional sessions per week or seek a more intensive form of treatment. For emergencies, please call 911. I am happy to discuss how therapy is meeting your needs at any time.

The Limits of Confidentiality

Your disclosures here will remain confidential. My utmost concern is to guard your privacy. Nothing discussed here will be disclosed outside the therapy room, except in rare cases as required by law.

By law, it is necessary for me to report any information I have regarding the following*:*

**If you are planning to take your own life*
*******If I determine that you are a danger to someone else*
** You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person*
**If you have knowledge of abuse or neglect taking place in a mental health or Rehabilitative facility*
**If you are a minor---your parents have the right to know about your progress*
**If your records are subpoenaed in connection with a legal proceeding*
**If a professional offering mental health services is being sexual with you*
**If you are in therapy along with someone else (i.e., couples or family therapy), these notes are the property of both parties, and can be obtained by any of the parties involved.*
**If required by the Secretary of the Department of Health for investigating compliance with the Privacy Rule.*

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking websites.

I consult regularly with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

Disclaimer

Although exploring medical, financial, legal, nutritional issues of a physiological nature are a part of therapy, psychologists are not physicians, CPAs, attorneys or nutritionists. Therefore, such information discussed in therapy should be further explored with an appropriate professional. Also, if you're entering therapy because you need an expert witness for a court case, your needs would best be served by a forensic psychologist who specializes in that. I can refer you.

Licensing

This practice falls under the jurisdiction of the Texas State Board of Examiners of Professional Counselors, P.O. Box 149347, Austin, Texas, 78714, (512) 834-6658, License Number 69673. If you are dissatisfied with my services at any time, please let me know.

Appointments & Finances

Therapy costs are as follows:

**50-minute individual session*	*$135.00*
**75-minute (1 hr. 15 min.) individual session*	*$200.00*
**90-minute (1 hr. 30 min.) individual session*	*$240.00*
**Phone calls involving counseling help*	*$2.70/minute*

Other services such as court appearances, travel time, writing reports or summaries, will be billed at the rate of $160 per 60-min hour/$2.70 per minute. I do not provide counseling services via email or text messaging. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room.

Cancellations: **If you must cancel an appointment *for any reason*, please give at least 24-hour notice. Otherwise, the credit card on file will be charged the regular session fee per the amount of time you scheduled.** Cancellations may be left on voicemail or email (682.556.4593 or ksoule@souletherapy.com). **This phone does not accept or receive text messages.**

Reserved Appointment Slots: If you have a regularly scheduled appointment, such as weekly or biweekly, you can always cancel without penalty up to 24-hours in advance. If you do not appear for a scheduled repeating appointment (e.g. weekly Tuesdays at 2:00pm) and do not contact me to cancel or reschedule, i.e. "no show," your repeating slot will no longer be reserved. If you cancel all upcoming appointments and do not reschedule, your weekly spot will no longer be reserved. You may contact me to reschedule for the same repeating spot if it is still available.

Late Arrivals: **If you are late to a session, I will wait 10 minutes, unless you call** (682.556.4593) to say you're on your way. Clients arriving late will for a session will receive the remainder of the scheduled appointment slot (e.g. 2:00pm-2:50pm) and will be responsible for the full fee.

Forms of Payment: Cash, check, and credit card are accepted as payment. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (courts, collection agencies, etc.) to obtain payment. Questions are welcomed.

Insurance Reimbursements: Please note that this office does not accept insurance, but upon request, I can provide documentation of out-of-network services for you to submit to your insurance company, if you choose to do so. Not all issues/conditions/problems which are dealt with in psychotherapy, are reimbursed by insurance companies. Cancellation fees are not likely to be covered. It is your responsibility to verify the specifics of your coverage. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk regarding confidentiality of computerized records.

My Contact Information

Email: ksoule@souletherapy.com
Cell Phone/Voicemail (**no texting**): 682.556.4593

If you need to contact me between sessions, please leave a voicemail on the phone number above and your call will be returned as soon as possible. **This phone does not accept or receive text messages.** I check my voice messages a few times during the daytime only, unless I am out of town. If an emergency situation arises, you can call 911, the Suicide Crisis Hotline 214-828-1000 or 1-800-273-TALK, or the MHMR Crisis line at 817-335-3022 or 1-800-866-2465 or the Police. Please do not use email or faxes for emergencies. I do not always check email or faxes daily.

This is a cell phone number. Email and cell phones cannot be guaranteed to be a secure and confidential form of communication. It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Emergencies

I **do not** provide 24 hour crisis counseling. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room. If there is an emergency where I become concerned about your personal safety or the possibility of you injuring someone else, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may contact the police, suicide assessment services, or other emergency personnel and/or the person whose name you have provided on the biographical sheet as the emergency contact. You may request at any time to update your emergency contact person.

Referrals

If at any time, you would like to terminate counseling with me or try working with another counselor for any reason including finances, please let me know, and I will provide referrals to other mental health professionals who may fit your needs.

Records

Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by state law, five years from the last date of contact. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify in writing. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Agreements

Mediation: *I agree that I will seek mediation in the event of any dispute with the therapist regarding the therapist-client relationship. All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator chosen will be one to which both parties can agree. The costs of mediation shall be equally shared. Judgment upon the award entered by the mediator shall be binding upon the parties and may be entered by either party in a court of competent jurisdiction.*

Court Involvement: *I agree that I am seeking treatment for the purpose of therapy only and not for legal purposes. I waive the right to subpoena the treating therapist and/or supervising therapists. If the therapist is subpoenaed by any party, I agree to compensate the therapist for time spent producing records and being present in court at the rate of $15 per hour with a minimum of two hours per court date.*

Therapist's Incapacity or Death: *I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.*

Contact: *I consent to the telephoning of my home, business, or cell phone numbers I have provided on the intake assessment form, including texting or having messages left on voicemail. I consent to communication by email for any email address I have provided. I understand that communication via email or on a cell phone is not considered secure and confidential.*

Emergency Contacts: *In the event that Kathryn Soule, PhD, LPC reasonably believes that I am a danger to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to suicide assessment services, medical and law enforcement personnel, and the following persons:*

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

A photocopy or fax of this consent is as valid as the original.

I have read and understand the above information (11 pages) and agree to the limitations and restrictions set forth herein. I have received a copy of this document and any questions have been answered to my satisfaction. **I voluntarily agree to receive mental health care, assessment, treatment, or services and understand I can terminate such services at any time**.

_____ _____
Client Signature Date

_____ _____
Kathryn Soule, PhD, LPC, Therapist Date

Kathryn Soule, PhD, LPC
4305 South Hulen St.
Fort Worth, Texas 76109

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read and understand this office's Notice of Privacy Practices, available in paper format in the office and online at www.souletherapy.com. Any questions I had have been answered to my satisfaction. I understand that I may request a paper copy to take with me at any time and one will be provided to me.

Patient name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____