Thomas W. Benedict, M.Ed., LPC-MHSP

Restoration: A Professional Counseling Practice, PLLC
1748 Lewisburg Pike, St.102
Franklin, TN 37064

Initial Therapy Intake Form

Client Information:

Client's Name_____
Client's Age_____ Client's Date of Birth_____
Address_____
Preferred Phone Number_____
How did you hear about our counseling services? _____
Occupation_____ Employer_____
Religious Preference (if any) _____
If client is a minor, name of responsible adult (guardian) _____
Emergency Contact person: _____Phone: _____

Therapy Goals and Client Stressors

What do you wish to achieve through therapy at this time?_____
_____
_____
_____
_____
_____
Briefly describe the history of this problem. _____
_____
_____
_____
_____
_____
Presently, and during the last two years, what are/have been some of the stressful events in your life (death of a loved one, loss of a relationship, job loss, family difficulties, disappointments, etc)? _____
_____
_____
_____
How do you usually handle stressful events in your life (ie: effective coping skills, ineffective coping skills, dangerous or harmful behaviors, acting out, isolating, etc): ____
_____
_____
_____

_____

Do you have a trauma or abuse history (victim of or witness to physical or sexual abuse, domestic violence, traumatic losses, difficult upbringing, etc). If yes, please describe:

_____
_____
_____
_____
_____

Medical/Mental Health History:

Any Previous Therapy/Counseling: _____
If yes, what type of therapy and how long did you attend? _____
_____
Was therapy beneficial to you? Why did you feel it helped/didn't help? _____
_____
_____
Are you currently in treatment with any other counselor or psychiatric provider? _____
Medical Problems (describe):_____
History of any hospitalizations (medical and/or psychiatric):_____
_____
Name of Primary Care Physician:_____Phone:_____
Name of Psychiatrist (if applicable): _____Phone: _____

Suicide Information:	**Check all that apply:**
None: no suicidal thoughts	□ I have never had thoughts of suicide
Mild: some thoughts, no plan	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past. □ I last experienced this on: Date:_____
Moderate: some thoughts, vague plan, low levels of lethality	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past □ I last experienced this on: Date:_____
Severe: significant thoughts, plan is specific and lethal	□ I am experiencing these thoughts now □ I have experienced these thoughts in the past □ I last experienced this on: Date:_____

Have you ever actually attempted suicide at any time in your life? **Yes / No**
If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:

_____
_____
_____
_____

Your Relationships

___Single ___Married ___Divorced ___Remarried ___Separated
___Widowed ___Engaged ___Living Together

Spouse's/Partner's name (if this applies): _____
Length of time together:_____
Your children's names and ages (if applicable): _____
Who currently lives in your home: _____
Please identify any areas of strength in your present relationship: _____

_____
_____
_____

Please identify any areas of need or struggle in your present relationship: _____

_____
_____
_____

Please identify any areas of significant conflict or trauma that you have experienced in your past or present relationships (ie: adultery/affairs, financial problems, sexual addiction, alcohol and/or drug addictions, domestic violence, etc):

_____
_____
_____
_____

Your Substance Use/Addiction History

Prescription Drug Use (Current names and doses): _____

_____

Previous Prescription Drug Use (names and doses): _____

_____

Any side effects?_____
History of Illegal Drug use? (describe):_____
Current Illegal Drug use? (describe): _____
Alcohol use/abuse (describe frequency and reason for use):_____

_____

Do you struggle with other addictive behaviors (overeating, constantly working, extreme shopping binges, gambling, sexual acting out, etc)? If yes, please describe. _____
_____
_____

Your Spirituality

What (if any) was your spiritual upbringing? _____
What (if any) is your current spiritual orientation? _____
Check all phrases that describe your current religious experience:

___Atheist	___Agnostic	___Curious
___Seeking God	___Spiritual…not religious	
___Pray often	___Skeptical	___Closed towards God
___Open towards God	___God is distant	___God loves me
___God is good	___God is cruel	___Communal Worship
___Stagnant	___Charismatic	___Fearful of God
___Strong Faith		

Symptom Assessment:

Check all of the following that apply to you over the last two weeks. Next to any that are checked, please mark 1-5 to assign severity to each symptom. 1=low severity, 5=very severe:

Emotional Symptoms-

__ anger	__ anxiety	__ extreme mood shifts
__ irritability	__ worrying	__ frustration
__ hopelessness	__ helplessness	__ fears
__ depression	__ apathy	__ lack of emotions
__ feelings of inferiority		__ panicky
__ guilt	__ unable to have a good time	
__ other (specify) _____		

Cognitive Symptoms-

__ problems with concentration	__ inattention
__ difficulty making decisions	__ distractibility
__ racing thoughts	__ memory problems
__ repeated unwanted thoughts	__ hallucinations
__ recurring nightmares	__ other _____

Physical Symptoms-

__ increase or decrease in appetite
__ tearfulness/crying spells
__ sweating/chills
__ stomach or intestinal distress
__ sleep difficulties
__ dizziness/fainting
__ shaky hands/feet
__ racing heart rate
__ body pain/numbness
__ frequent or severe headaches
__ muscle tension
__ other _____

Behavioral Symptoms-

__ hyperactivity __ impulsivity __ binge eating/overeating
__ suicidal gesture/attempt history __ present suicidal thoughts
__ verbal aggression __ physical aggression
__ social withdrawal __ induced vomiting
__ self-injury __ increased alcohol/drug use
__ disorganization __ oppositional/defiant
__ lying/deceitfulness __ sexual problems
__ financial problems __ avoidance of school or job
__ relationship problems __ other_____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

_____ _____
Client Signature (if completed by client) **Date**

_____ _____
Signature of Legal Guardian of Client under the age of 16 **Date**

_____ _____
Counselor Signature (if completed by counselor) **Date**

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Counseling Policies and Processes:

Entering into a therapeutic relationship with a counseling professional requires an establishment of trust. When you begin therapy, you are committing your time, money and emotional energy and it is important to fully understand what that commitment will entail. Included below is a summary of the policies and processes that guide your work with me as your therapist.

1. **PROFESSIONAL BACKGROUND: I hold a Master's of Education in Clinical Mental Health Counseling. I have worked in the counseling field since 2005 and my scope of practice has included family counseling, individual counseling with children and adults, and couples counseling. I have additional training, beyond my M.Ed., including EMDR, Splankna (Level 1), and TFCBT (Trauma Focused Cognitive Behavioral Therapy).**

2. **APPOINTMENTS:** You can make an appointment by calling 615-487-4745 between the hours of 9:00am and 8:00pm. If I am unavailable to take your call, please leave a confidential message so that I can return your call within 24 hours. Since clients are seen by appointment only, unless an emergency requires an immediate appointment, this appointment time is reserved only for you. If it is necessary for you to cancel an appointment, notice of cancellation must be made at least 24 hours prior to your scheduled appointment time or you will be billed for the set appointment fee. If you are experiencing a mental health emergency and cannot reach me, please go directly to your nearest emergency room for assistance or call the Crisis Help Line at 244-7444.

3. **FEES AND PAYMENTS FOR COUNSELING SERVICES:** Fees for counseling services will be determined prior to counseling beginning or within our first session, with sessions for individuals and couples running 50 minutes. Payment is due at the beginning of your session time to allow for the remainder of the therapy session to focus on therapeutic issues. Payment for consulting and court-ordered appearances will be discussed and agreed upon before services are rendered for these special circumstances.

4. **CONFIDENTIALITY:** Tennessee State law and ethical requirements of the State Board indicate that what we discuss in our private counseling sessions is privileged communication, meaning that you as the client control the release of this information to a third party. There are several limits to confidentiality that involve the required release of information in order to keep you and/or others safe

from harm. These limits include: clear and imminent danger to self or others; suspected child or elder abuse; a direct court order by a judge ordering me to release records or appear in court to testify. If it would benefit you in your counseling progress, I may ask you to sign a release of information to allow me to discuss information with your primary heathcare professional or other key providers in your life (ie: a psychiatrist or a previous counselor).

5. **HIPAA NOTICE OF PRIVACY PRACTICES:** Included with this initial introductory paperwork, you should have received a copy of the HIPAA document. I am required by law to provide this to you and to secure your signature. If you should have any questions about this document, please do not hesitate to ask me for clarification.

6. **BENEFITS AND RISKS OF COUNSELING:** Counseling can be of great benefit to a client who fully commits to being open and honest in the counseling relationship. It requires the client to come to the table with their own personal goals for counseling. I cannot create change in your life; you are the change agent in your own life. I cannot guarantee a specific outcome from our time together. Clients are ultimately responsible for their own growth and direction in counseling. Counseling also has risks that may include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of counseling may include: facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, and recalling unpleasant life events. I am available to discuss any of your problems or possible side effects of our work together. Also, during our counseling sessions, we may discuss additional resources or activities that added to counseling may help further your change and growth. These may include referrals to a PCP for medication evaluation, directions for a specific activity plan of exercise, referrals to a nutritionist, etc. Wellness comes from whole body health that should include an emphasis on mind, body and spirit. After we have met to discuss your concerns, we will create a plan that is individualized to your own goals and desires for counseling outcomes.

Please feel free to discuss with me any of the policies and processes outlined above. It is important that you clearly understand your rights and responsibilities when entering a counseling relationship.