Thank you for inquiring about the INTACT Counseling Group! We are honored to have the opportunity to serve your counseling needs. It takes great courage to reach out and ask for assistance at difficult times – but YOU did it! You and your loved ones are worth being supported, nurtured and strengthened.

You will find an INTACT Intake Packet attached for your completion prior to your first session with a therapist. Please take your time to complete it thoroughly and thoughtfully as it helps us determine the best treatment approach to use to get you where you want to be in life and in relationships. Please feel free to ask any questions you may have about the work that we do at INTACT – we are here for you.

The offices of the INTACT Counseling Group are located at:

INTACT Counseling Group
9200 Montgomery Road
Building D
Suite 15B
Cincinnati, OH 45242

General Information and scheduling: 513.600.2554, ext. 0 (Sharon Frankart, Business Manager)

Contact Information for our counselors:

Steven Andry, LPCC-S, CSAT-S, DARTT Phone: 513.600.2554, ext. 2

Jane G. Edelmann, LPCC, CSAT, CPTT-Candidate, DARTT Phone: 513.600.2554, ext. 1

Jacinda R. Jaymes, LPC, CSAT-Candidate, DARTT Phone: 513.600.2554, ext. 4

Andrew L. Rickenbach. LPCC, CSAT-Candidate, DARTT Phone: 513.600.2554, ext. 3

Directions to our offices:

INTACT is located near the center of "downtown" Montgomery, just south of where Eastbound Ronald Reagan Highway (SR 126) dead ends into Montgomery Road.

Turn **RIGHT** (south) onto Montgomery Road.

Take an **IMMEDIATE LEFT** at the first street light (Kennedy Drive) at the entrance of Montgomery Station Office Condos. Drive through the **first stop sign** and then veer to the **RIGHT** where the road divides.

Proceed to **Building D** on your RIGHT. **Suite 15B** is at the very end of this building. Name on the Building is **INTACT Counseling Group**. (Proceed down the steps)

INTACT Intake Form

Please fill out this biographical background form as completely as possible as it will help in our work together. Please print or write clearly and bring this form with you to the first session.

Name: ____ Appointment Date: _______________________

Male/Female: ___________ Age: ________ DOB: ___________ Marital Status: S / M / D / Sep / Partnered

<u>Phone Communications</u>

____ OK to contact me at this phone number (Circle H / W / M) : __________________________________

____ OK to text appointment information on cell number listed above

____ OK to leave message with your name and call-back # on voicemail or answering machine

____ OK to give appointment information to following individual(s): _______________________________

<u>Written Communication</u>

___ Do not mail any written client information to me

___ OK to mail any written client information to the address on file

___ OK to mail my client information to other address: ____

___ You can communicate by E-mail with me at: ____

Home Address: ____

Referral Source: ____

Person to call in an emergency:_________________________________ Phone: ________________________

What is his/her relationship to you? ____

PRESENTING PROBLEM

Please explain the problem you wish to address in therapy. Be as specific as you can and include when it began and how it is currently affecting you.

____

____

____

____

How much distress is this problem causing you on scale of 1-10 (10 being most distress)? ____________

Self Harm: Are you currently experiencing thoughts of harming yourself or someone else? __Yes __No

If yes, please describe: ____

EDUCATION/OCCUPATION Highest Grade Completed: ___________ Date of completion: _____________ Degree(s): _______________________ How many jobs have you had in the last 5 years ___________________

Current Occupation: ____

On a scale of 1-10 with 10 being the most stressful, how stressful is your job right now? _______________

MENTAL HEALTH TREATMENT HISTORY

Provide past and present mental health treatment (i.e. hospitalizations, psychotherapy, pastoral counseling, group therapy) including dates of treatment, treatment setting (outpatient, inpatient, residential), and reason for treatment.

1. ____

____

2. ____

____

List past and current psychotropic medications taken, their effectiveness, and why they were discontinued:

____

____

Past suicide attempts or violent behavior (describe: ages, reasons, circumstances, how, etc.):

____

____

SUBSTANCE USE/TREATMENT HISTORY

Do you drink socially? _____Yes _____ No. If yes, how many drinks do you have per week? ___________

Do you think that you may have a problem with alcohol or drugs? ______Yes ______No _______Unsure

Do you currently attend AA, NA, SA, or another addiction support group? ______Yes _____ No (# ____)

Have you ever received treatment for drug, alcohol, gambling, or other abuse or addiction?
_____Yes _____No. If yes, please provide past treatment dates, provider name, and type of treatment (outpatient,inpatient,residential):____

____

Does someone in your family have an addiction to or abuse alcohol or drugs? _____Yes _____No

Describe: ____

MEDICAL HISTORY Past & present medical care (only list major medical problems, surgeries, accidents, falls, illness, etc.

____

Specify medication(s) you are presently taking and for what. Please print clearly:

____

____

Pertinent Family Medical History (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

____

____

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COUNSELING

LEGAL HISTORY Are you involved in any current or pending civil or criminal litigations, lawsuits, divorce proceedings or custody disputes? ______Yes ______No (If yes, please explain):

____

____

Have you ever been in jail? _____Yes _____No (If yes, provide dates and the nature of the event):

____

____

SPIRITUAL HISTORY Please describe your church background (how you were raised). ________________

____

How important is your spirituality/faith and what does it look like today? ____________________________

____

Do you want to integrate spiritual matters/faith into your therapy sessions? ____Yes ____No ____Unsure

FAMILY HISTORY Please list past and present significant relationships, number of years together (if applicable), and a brief statement about the nature of the relationship, (i.e., friendly, distant, physically/emotionally abusive, loving, hostile, supportive).

Spouse/Significant Other Name	Age	Yrs. Together	Nature of Relationship

*Present Spouse/Significant Other's Occupation: ____

Children's Name(s)	Age	Nature of Relationship

On a scale of 1-10 (10 being the most stressful) how stressful is parenting for you at this time? ________

Parents' Name(s)	Age (or yr of death)	Nature of Relationship

*Are your parents divorced? ___Yes ___No If yes, what was your age at the time of divorce? ________ Please briefly describe how parents' divorce affected you at the time and if it still affects you today:

____

____

<u>Sibling Name(s)</u> <u>Age</u> <u>Nature of Relationship</u>

____

____

____

____

Describe your childhood in general (positive, negative, or neutral, and anything noteworthy):

____

Please provide any significant family history of mental illness, alcoholism, substance abuse, violence, or legal involvement (including suicide, depression, psychiatric hospitalizations, abuse, treatment for addiction, etc.).

____

____

CULTURAL HISTORY Please describe your cultural and ethnic upbringing:

____

____

OTHER Do you feel that your current technology use is balanced and healthy? ______Yes ______No ______ Unsure. If not, please explain: ____

____

Estimate how many hours per day you spend online on the following:

Social Media: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______ Other: ________

SEXUAL INVENTORY (PATHOS)

Do you often find yourself **preoccupied** with sexual thoughts? ___Yes ___No
Do you hide some of your sexual behavior/**activities** from others? ___Yes ___No
Have you ever sought **treatment** for sexual behavior you did not like? ___Yes ___No
Has anyone been **hurt** emotionally because of your sexual behavior? ___Yes ___No
Do you feel **out-of- control** of your sexual desire? ___Yes ___No
When you have sex, do you feel depressed or **sad** afterwards? ___Yes ___No

ABUSE/TRAUMA HISTORY Do you see yourself as having been abused in any of the following ways? If so, please indicate the level of severity.

__ Physical __ Minor, __ Moderate, __ Severe

__ Sexual __ Minor, __ Moderate, __ Severe

__ Emotional __ Minor, __ Moderate, __ Severe

__ Other __ Minor, __ Moderate, __ Severe

Have you received prior treatment related to any issues of abuse identified? __ No __ Yes

Do you seek further treatment for abuse related issues? __ No __ Yes

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

   No___ Yes ___

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   No___ Yes ___

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   No___ Yes ___

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   No___ Yes ___

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   No___ Yes ___

6. Were your parents ever separated or divorced?

   No___ Yes ___

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   No___ Yes ___

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   No___ Yes ___

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   No___ Yes ___

10. Did a household member go to prison?

   No___ Yes ___

Now add up your "Yes" answers: _____ (This is your ACE Score)

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COUNSELING

PROFESSIONAL SERVICES AGREEMENT

This agreement for counseling services is between: **INTACT COUNSELING GROUP**, your therapist, and ____ (Client) shall govern all professional relations between the parties. It is agreed that any disputes or modifications of agreement shall be negotiated directly between the parties; if these negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator, considering first the owner of the practice.

A. THERAPIST

Your therapist will be ____. Please refer to the Professional Disclosure Statement provided to you for the specific licenses and qualifications of your therapist.

B. FEES

INTACT Counseling Group fees are $145.00 per 50-minute session. ($215.00 for an initial 90 minute session if the additional time is deemed necessary.) Lateness on the part of the client, or leaving early, does not reduce the fee. Clients are fully responsible for all fees. We cannot extend credit or schedule appointments beyond two (2) unpaid sessions until payment is made.

C. FORENSIC ASSESEMENTS, COURT APPEARANCES, ETC.

It should be understood that legal and ethical standards may prohibit the utilization of your therapist as a forensic/expert witness (e.g., in child custody cases) in keeping with ORC 4757-6-01. Additional fees are applicable in the event of your therapist being called to testify. Billable hours for court appearance, preparation, and travel time shall be $250.00 per hour. All expenses for travel, consultation, record preparation and appropriate professional expenses shall be reimbursed by the client.

D. CANCELLATION POLICY

We agree to and ask that clients maintain responsible relations regarding appointment times. Any appointment cancelled less than 24 hours before the scheduled appointment time or that the client does not show will be charged to the client at the full rate.

E. CONFIDENTIALITY POLICY

All therapeutic communications, records, and contacts with professional and support staff will be held in strict confidence. Information may be released, in accordance with state law, only when:

(1) the client signs a written release of information indicating informed consent to such release;
(2) the client expresses serious intent to harm himself/herself or someone else;
(3) there is evidence or reasonable suspicion of abuse against a minor child, elder person (sixty-five years or older), or dependent adult, or evidence of domestic violence.
(4) a subpoena or other court order is received directing the disclosure of information.
It is our policy to assert either (a) privileged communication in the event of #4 or (b) the right to consult with clients, if at all possible barring an emergency, before mandated disclosure in the event of #2 or #3. Although we cannot guarantee it, we will endeavor to apprise clients of all mandated disclosures.
(5) Clients with any concerns or questions about this policy agree to raise them with their counselor at the earliest possible time to resolve them in the client's best interest.

F. INTER-AGENCY CONSULTATION

In our efforts to provide the most integrated and clinically comprehensive care, licensed mental health professionals may seek consultation with other therapists within the agency unless otherwise specified by the client. We do our best to protect the confidentiality of the individual clients and couples with whom we are working. If you have questions about this practice please discuss this your individual therapist.

G. ELECTRONIC SERVICE DELIVERY (INTERNET, EMAIL, TELECONFERENCE, ETC.)

In keeping with Ohio Revised Code 4757 please note the following:

(1) All electronic communication (email, texts, etc.) shall be encrypted. If you wish to communicate with your therapist via email, please discuss with her/him an appropriate means (such as www.hushmail.com) to sufficiently allow for encryption of electronic communication. It is otherwise prohibited by Ohio Law in order to protect your confidentiality.

(2) Teleconference, or eTherapy, must meet all requirements as stated in Ohio Revised Code 4757-5-13 and participants must complete the eTherapy Professional Services Agreement with INTACT Counseling Group.

H. WORK AGREEMENT

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Client gain is most important in professional counseling. It is understood that there may be spiritual content introduced during the course of therapy. Suspension, termination, or referral shall be discussed between counselor and client for a pattern of behavior that reveals disinterest or lack of commitment to counseling or for any unresolved conflict or impasse between counselor and client.

H. CONTINUTY OF CARE

In the event that your primary therapist becomes unable to provide care for you, every effort will be made to facilitate a transfer to another therapist of the INTACT Counseling Group staff. In the event that no INTACT Counseling Group staff member is available, appropriate referrals will be provided. In the case of an emergency please use the appropriate authorities (911) as needed.

I. DIAGNOSIS OF MENTAL AND EMOTIONAL DISORDERS

Therapists associated with the INTACT Counseling Group LLC are licensed (independently or under supervision) as a mental health professional to make a diagnosis of mental and emotional disorder(s) in accordance with the Diagnostic and Statistical Manual V. In the event that insurance billing occurs, information regarding that diagnosis will be released to the insurance and will become part of the client's medical record. Should the client have questions about the implications of such a release it is important that he or she voice those concerns with the therapist.

Client Signature: ____ Date: __________________

Parent/Legal Guardian (for those under 18): ______________________________ Date:___________________

Therapist Signature: ____ Date: __________________

Supervisor Signature (if applicable): _______________________________________ Date: __________________

PERMISSION TO EMAIL APPOINTMENT REMINDERS

Therapists associated with the INTACT Counseling Group LLC have the ability to send reminders via email for upcoming appointments. This is done through our note taking system. This service is not required but offered as a convenience to our clients.

If you would like an email reminder, please fill in the information below:

Email address: ____

Please Print Name: ____

Client Signature: ____ Date: __________________

Parent/Legal Guardian (for those under 18): __________________________________ Date:___________________

Therapist Signature: ____ Date: __________________

Supervisor Signature (if applicable): ____ Date: __________________