Lighthouse Counseling Intake

521 State Street
St Joseph Michigan 49085
(269) 408-6031
www.lightousecounseling.org

Client Information: **Today's Date_____**

Name: Last_ First_____ Middle_____

Address_____ City_____ State_____ Zip Code_____

Phone (Home)_____ Work_____ Cell_____

Which number do you prefer we use? _____ Can we leave a message?_____

E-mail Address_____ may we contact you by email?_____

Marital Status_____ [S-Single, M-Married, W-Widowed, D-Divorced, P- Separated]

Sex_____ Date of Birth_____ Age_____ Social Security # _____/_____/_____

Emergency Contact_____Phone_____ Relationship_____

Employment Information:

Employer_____ Occupation_____

Employer Address_____

Phone Number_____ Address_____

Who is Financially Responsible for this Account?

Name:_____ Relationship_____

Date of Birth_____ Social Security# _____

Address_____ City_____

State_____ Zip_____

Insurance Company Name_____

Group Number_____ Insured's ID#_____

Do you have Employee Assistance? _____ If so what is your authorization number_____

_____ _____
Signature of client Date

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Hypnotherapy Intake Questionnaire

1. List three of your favorite colors:_____
2. Name three of your favorite places:_____
3. List any fears or issues:_____
4. Do you suffer any compulsive tendencies?_____
5. List any current health issues:_____

_____

_____

6. List the medications you are taking:_____

_____

7. List three of your most important lifetime goals:_____

_____

8. List of your pastimes or hobbies:_____
10. Do you enjoy your current work?_____
11. List things that you like to do but would like to do better:_____

_____

12. If you could what would you wish for, become or do?_____

_____

13. Why are you seeking hypnosis?_____
14. How did you find this office?_____
15. Are you currently suffering from any of the following:

- ☐ _ Nervousness
- ☐ _ Inability to relax
- ☐ _ Sleeplessness
- ☐ _ Depression
- ☐ _ Sexual dysfunction
- ☐ Compulsive tendencies
- ☐ Nail biting
- ☐ Nightmares
- ☐ Childhood trauma
- ☐ Fear of heights
- ☐ Poor self-esteem
- ☐ Poor health
- ☐ Cigarette smoking
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Compulsive overeating
- ☐ Serious eating disorder
- ☐ Codependency
- ☐ Inability to focus and keep attention
- ☐ Abusive home situation
- ☐ Abusive work issue
- ☐ Sexual abuse
- ☐ Poor memory
- ☐ Marital problems
- ☐ Recent divorce
- ☐ War trauma
- ☐ Current illness
- ☐ Teeth grinding

- ☐ Lack of energy
- ☐ Death of a loved one
- ☐ Death of a pet
- ☐ Lack of success
- ☐ Any other important issues_____

16. One thing I feel guilty about is:_____
_____
17. I am happiest when:_____
_____
18. If I were not afraid to be myself I would:_____
_____
19. I get so angry when:_____
_____
20. I am most saddened by: _____
_____
21. All of my life I: _____
_____
22. Ever since I was a child I_____
_____
23. One of the ways I could help myself but I don't is:__ _____
_____
24. It is hard for me to admit: _____
_____
25. I am a person who: _____
_____
26. A mother should: _____
_____
27. A father should: _____
_____
28. A true friend should: _____
_____

29. Mention your most significant memory, experience, or event that corresponds to each of these following periods of time in your life:

0-5 years old: _____
_____
6-10: _____
_____
11-15: _____
_____
16-20: _____
_____
21-25: _____
_____
26-30: _____
_____
31-35: _____
_____
36-40: _____

_____

41-45: _____

_____

46-50: _____

_____

30. What behaviors get in the way of your happiness?_____
31. What would you like to start doing?_____
32. What would you like to stop doing?_____
33. What would you like to do more of?_____
34. What would you like to do less of?_____
35. What makes you laugh?_____
36. What makes you cry?_____
37. What makes you happy?_____
38. What makes you sad?_____
39. What makes you mad?_____
40. What makes you frightened?_____
41. What do you see or imagine yourself as doing in the next 6 months?_____

_____

42. What do you see or imagine you are doing 5 years from now?_____

_____

43. What would you like to be doing 5 years from now?_____

_____

44. What would have to change or be different for that to happen?_____

_____

45. What are your main beliefs and values?_____

_____

46. What are the things you feel you should, can, and must do?_____

_____

47. What motivates you?_____
48. In one word describe your life:_____
49. In one word describe your problems:_____
50. In one word describe the good times in your life:_____
51. One of the things I feel proud of is:_____
52. Do you observe any religious or meditative practice? If so describe:_____

_____

53. Do you believe in past lives?_____
54. Please explain any other negative conditions affecting you:_____

_____

55. Please list any additional needs or concerns:_____

Stress Level Profile

Instructions: Read each statement below and enter the number to the right of it that best represents you and your behavior at this time.

1 - not at all 2 – slightly 3 – moderately 4 - very much

1. I often lose my appetite or eat when I am not hungry ____
2. My decisions seem to be more impulsive than planned, I tend to feel unsure about my choices & often change my mind ____
3. The muscles of my neck, back and stomach frequently get tense ____
4. I have thoughts & feelings about my problems that run through my mind for much of the time ____
5. I have a hard time getting to sleep, wake up often or feel tired ____
6. I feel the urge to cry or get away from my problems ____
7. I tend to let anger build up & then explosively release my temper in some aggressive way or destructive way ____

8. I have nervous habits (tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands, etc. ____
9. I often feel fatigued, even when I have not been doing physical work ____
10. I have regular problems with constipation, diarrhea, or upset stomach ____
11. I tend not to meet my expectations either because they are unrealistic or I have taken on more than I can handle ____
12. I periodically lose my interest in sex ____
13. My anger gets aroused easily ____
14. I often have bad unhappy dreams or nightmares ____
15. I tend to spend a great deal of time worrying about things ____
16. My use of alcohol, coffee, cigarettes, and/or drugs has increased ____
17. I feel anxious, often without any reason that I can identify ____
18. In conversation my speech tends to be weak, rapid, broken, or tense ____
19. I tend to be short tempered and irritable with people ____
20. Delays, even ordinary ones, make me fiercely impatient ____

Challenges Checklist

Using a scale of 1-5 (with 1 being the most important and 5 being the least important), place the appropriate number on the lines below. Leave blank the issues that don't apply to you.

☐	Need a job	
☐	Worn out by job	
☐	Cannot save money	
☐	Cannot get ahead	
☐	Problems with co-workers of boss	
☐	Dislike job or __School	
☐	Too much time to spare	
☐	Bad habits	Describe
☐	Drug problems	Substance(s)
☐	Drink too much	What and how much?
☐	Weight problems	Desired weight
☐	Eat too much	What?
☐	Not enough exercise	Minutes/week
☐	Dissatisfied with appearance	Why?
☐	Want to quit smoking	Cigarettes/day
☐	Difficulty falling asleep	
☐	Cannot stay asleep	
☐	Poor memory	
☐	Studying is dull	
☐	Read too slowly	
☐	Poor concentration	
☐	Fears/issues	Of what?
☐	Afraid of people	
☐	Low self esteem	
☐	Think about suicide	
☐	Fear of dying?	
☐	Too emotional	
☐	Too nervous	

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☐	Guilty feelings	
☐	Negative reaction to stress	
☐	Difficulty relaxing	
☐	Bad dreams	
☐	Feel awkward	
☐	Dislikes people	
☐	Cannot express emotions	Specify
☐	Frequently cry	
☐	Different than others	Describe
☐	Fear responsibility	
☐	Anger Quickly	
☐	Too critical of others	
☐	Violent/verbally abusive when angry	
☐	Do not trust others	
☐	Too sensitive	
☐	Feel sad frequently	
☐	Do not communicate	
☐	Speech problems	
☐	Fear of public speaking	
☐	Lack skills	
☐	Poor vision	
☐	Wear glasses	
☐	Procrastinate a lot	At work__ With personal stuff__
☐	Poor organization	
☐	Would like to raise income	Presently:$___/yr Desired:$___/y
☐	Want to change career__ or job__	
☐	Afraid to take risks	Personal__ Business__
☐	Blame others	
☐	Want to know my life mission	
☐	Need more goals	
☐	Lack of motivation__ ambition__	
☐	Trouble making decisions	
☐	Lack of education	
☐	Lack imagination	
☐	No time to relax	
☐	Desire more fun	
☐	Unwanted emotions	Specify
☐	Wanted emotions absent	Specify
☐	Depression: Frequency_____	
☐	Too Pessimistic	
☐	Legal Problems	
☐	Cannot get up in the morning	
☐	Get sick a lot	
☐	Fear of poor health	

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- ☐ Fear of mental health worsening
- ☐ Aging faster then I prefer
- ☐ Desire rejuvenation/slowing done of aging
- ☐ Lack of energy
- ☐ Blood pressure too High__ or too Low__
- ☐ Menopause difficulties
- ☐ Allergies Types/symptoms
- ☐ Physical pain
- ☐ Spiritual problems
- ☐ Difficulty meeting people For Business___ or Personal____
- ☐ Grieving Specify
- ☐ Feel lonely
- ☐ Too shy
- ☐ Want a love relationship
- ☐ Desire more sex
- ☐ Unhappy marriage
- ☐ Divorce
  - Contemplating___ going through___ are__
  - Relationship __breakup or __breaking up
- ☐ Trouble with children
- ☐ Trouble with a loved one
- ☐ Quarreling at home
- ☐ Difficulty making friends
- ☐ Am not assertive With business_____ or personally_____
- ☐ List any other Challenges_____ _____

RELEASE STATEMENT

I hereby authorize Briana Dixon to hypnotize me for the purposes outlined in this intake form and for the future purposes that I may request. I understand that the success of my hypnosis therapy depends greatly on my own ability and desire to effect change in myself. I understand that the results of my sessions depend greatly on my own serious participation, and that Briana cannot offer any guarantee of the success of my treatment. I am aware, however, that Briana will do everything in his power to ensure my success. I also understand that I have other choices from which to seek assistance regarding my specific concerns, and I have chosen hypnotherapy at this time.

Signature of client Date

I understand that during the hypnotherapy session, Briana Dixon may touch me as an anchoring technique. I hereby give my permission for such touch to take place during my session.

Signature of client Date

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

LIGHTHOUSE COUNSELING
guiding families to a better life

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AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to _____ at
NAME/AGENCY_____
ADDRESS_____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

___ Summaries and notes of participation in treatment
___Evaluations and Recommendations
___Psychological and psychiatric testing & evaluation results
___Treatment Plan, Progress & Discharge reports
___Information relating to medical history
___Information relating to social history
___Other information_____

C. PURPOSE. The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW

___ Assessment
___ Diagnosis
___ Psychological Evaluation
___ Treatment Plan or Summary
___ Progress in Treatment
___ Billing Information
___ Coordinate Treatment Services_____
___ Other_____
____ Testing Information
____ Education Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Medication List
____ Verbal Consultation

I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.
___Substance abuse (drug or alcohol) information
___Mental Health information
___AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months

_____ _____
Signature of client Date

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CLIENT RIGHTS AND RESPONSIBILITIES/EXPLANATION OF SERVICES

Counseling is a collaborative process with your therapist/counselor that involves…….

- **Exploring** the issues that brought you to therapy.
- **Building** a trusting relationship with your therapists.
- **Deciding** upon specific goals and objectives.
- **Working** toward these goals and objectives
- **Evaluating** your progress on a regular basis.

I understand…..

· That I have chosen to receive treatment services and I may terminate my therapy/counseling at any time, unless ordered by the court.
· That there is no assurance that I will feel better.
· That during the course of my treatment, material may be discussed that is upsetting in nature. This is a part of the therapy/counseling process and may be necessary to resolve my concerns.
· That I may be contacted by my health plan to ensure continuity and quality of therapy/counseling or after the completion of treatment to assess the outcome of treatment.
· That records and information collected during my treatment will be held or released in accordance with Federal and State laws regarding confidentiality of such records and information.
· That State and Local laws require that my therapist report all cases where there exists a danger to self or others.
· That there may be other circumstances in which the law requires my therapist/counselor to disclose confidential information.

I have the right…….

· To be treated with dignity, consideration, and respect at all times.
· To expect quality service provided by concerned, trained, professional and competent employees.
· To expect complete confidentiality within the limits of the law and to be informed about the legal exceptions to confidentiality and to expect that no information will be released without the client's knowledge and written consent.
· To appropriate information regarding employee education, training, skills, license, and practice limitations and to request and receive referrals to other clinicians when appropriate.
· To be a collaborative partner with my therapist/counselor in the development of treatment plans and goals.
· To obtain information about case records and to have this information explained clearly and directly.
· To request information and/or consultation regarding the conduct and progress of services.
· To refuse any recommended services and to be advised of the consequences of this action.
· To a safe environment free of emotional, physical, and sexual abuse.
· To a client grievance procedure, including requests for consultation and/or mediation and to file a complaint with a supervisor and/or the appropriate credentialing body.
· To make an informed decision about whether to accept or refuse treatment.
· To contact and consult with counsel at my expense.
· To a clearly defined ending process and to discontinue services at any time.

I am responsible for…….

· Being on time for my appointments.
· To cancel appointments that I am unable to keep, within a timely manner.
· Informing my therapist of any change in residence or work telephone numbers and/or address.
· Contacting my therapist to confirm my appointment on days when the weather is inclement.

_____ _____
Signature of client Date

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COUNSELING
guiding families to a better life