Creative Solutions Counseling
Finding solutions for today's problems.

Change. Possible.
JOE MARTINO COUNSELING

Client Intake Form

Name:_____. D.O.B. _____

Gender:_____ EMAIL: _____

Preferred method of contact? _____

ADDRESS: _____

CITY: _____ ZIP: _____

PHONE: _____ MOBILE PHONE: _____

PRIMARY? _____ May we leave a message? ☐Yes ☐No

Occupation: _____ Total Hours a week _____

Briefly describe the type of work you do, does it contribute to your stress?

_____
_____
_____
_____

Do you enjoy what you do? ☐yes ☐No

Does your job interfere with your sleep schedule? ☐yes ☐No

Employer: _____ Phone number _____

2305 East Paris SE Suite 203 Grand Rapids Mi 49546
www.creativesolutionsgr.com
616-929-0226

11630 Fulton Street E Lowell Mi 49331
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616-481-3784

Marital Status:

☐Never Married/Partnered ☐Married/Partnered ☐Divorced ☐Widowed ☐Separated

☐Living together ☐Involved in multiple relationships

How long have you been with your current partner/spouse _____

Have you been separated from your current partner/spouse _____

Partners/Spouse's Name_____ Occupation_____

Does he or she know that you are seeking counseling? ☐yes ☐No

Do you have children? ☐yes ☐No

Please list children and ages:

Name	Age	In your home?

Who may we contact in the event of an emergency?

Name: _____ Phone _____ Work Phone _____

Relationship: _____

Reason Questionnaire.

Please describe in your own words why you are coming to counseling.

_____
_____
_____
_____
_____
_____

Have you attempted suicide in the last 12 months? ☐yes ☐No

Have you attempted to self-harm in the last 12 months? ☐yes ☐No

Have you been to counseling before? ☐yes ☐No Where? _____

When? _____ How long? _____

Describe that experience:

_____
_____
_____
_____

Are you currently taking any medications? ☐yes ☐No Please list all medications and dosage.

Medication	Dosage

Please check all that apply:

Feelings:	
☐Helpless	☐Anxious
☐Depressed	☐Out of control
☐Shameful	☐Afraid
☐Angry	☐Numb
☐Guilty	☐Relaxed
☐Hopeless	☐Happy
☐Lonely	☐Excited
☐Sad	☐Hopeful
☐Distressed	☐All over the place

Thoughts:	
☐Confused	☐Racing
☐Worthless	☐Obsessive
☐Dumb	☐Distracted
☐Unmotivated	☐Organized
☐Ugly	☐Hopelessness
☐Unlovable	☐Sensitive
☐Confident	☐Angry
☐Homicidal	☐Honest
☐Suicidal	☐All over the place

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Please check all that apply:

Symptoms/Behaviors		
☐Eating habits changed ☐Procrastinating ☐Attempted suicide ☐Poor concentration ☐Crying ☐Withdrawing socially ☐Skipping class/work ☐Binge Drinking ☐Injuring Self ☐Compulsive activities ☐Major Choice ☐Sexually Acting Out ☐Acting Aggressively ☐Disorganization ☐Impulsivity ☐Recklessness ☐Irritability ☐Passivity ☐Alcohol Use	☐ Drug Use ☐Self-Harm ☐Sexual Dysfunction ☐Unsafe Sex habits ☐Marital Problems ☐Familial Problems ☐Parent/Child Issues ☐Lack of Ambition ☐Poor Peer Relationships ☐Night Mares ☐Worries about body image ☐Spiritual Problems ☐Dating Issues ☐Financial Issues ☐Compulsive Masturbation ☐Porn Issues ☐Addiction issues ☐Weight Gain/Loss rapidly ☐Tired all the time	☐Frequent Headaches ☐Tightness in Chest ☐Dizziness ☐Lightheadedness ☐Numbness/Tingling ☐Vomiting ☐Self-starving ☐Rapid Heart Beat ☐Excessive Sleep ☐Loss of memory ☐Other eating Problems ☐Pregnant ☐Pregnancy issues ☐Divorce (recent) ☐Death of a loved one ☐Diagnosed with terminal illness ☐Job loss ☐Other (please explain below

Is there anything else you would like to tell us?

_____
_____
_____
_____
_____
_____
_____
_____

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Are you currently sexually active? ☐Yes ☐No

Are you practicing safe sex? ☐Yes ☐No

If married or partnered are you active with someone other than your partner or spouse?

☐Yes ☐No

Do you find fulfillment in your sex life? ☐Yes ☐No

Is there anything you would like to add?

_____
_____
_____

With 1 meaning needs a lot of improvement and 10 meaning completely satisfied would you please rate the following on a scale of 1-10

Mental Please write one thing that could cause this number to go up a little
1---2---3---4---5---6---7---8---9---10
Physical _____
1---2---3---4---5---6---7---8---9---10
Social _____
1---2---3---4---5---6---7---8---9---10
Spiritual _____
1---2---3---4---5---6---7---8---9---10
Emotional _____
1---2---3---4---5---6---7---8---9---10
Vocational _____
1---2---3---4---5---6---7---8---9---10

Were you referred to us? Yes ☐No
If yes, by whom? _____

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COUNSELING AGREEMENT FOR NEW CLIENTS

COUNSELING SERVICES. The decision to begin counseling may have important consequences for the rest of your life. Research has shown that when individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve good results. This document contains important information about the professional services you will receive. **Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between Creative Solutions Counseling and yourself.**

APPOINTMENTS. Individual appointments are generally 45 minutes in length. If for any reason you are unable to keep your appointment, it is essential for you to notify us 24 hours in advance of your scheduled appointment. If you do not, you may be charged for the time reserved for you. If you do need to reschedule an appointment, we will cooperate in accommodating your preferences.

RATES & PAYMENTS. It is our mission to make professional counseling services affordable for everyone. The average cost per counseling session for professionals with similar licensure and credentials is approximately $165 per session. This is our regular rate, but in order to make counseling more accessible to the community, we have discounted our fees and have created a sliding scale based on household gross income. **We will give you this form upon request. Not all of our counselors utilize a sliding scale as Joe Martino Counseling is a collection of independent counselors sharing resources and a common goal of helping the community.** *As it is our wish that no one is turned away from receiving counseling services, if you find that you cannot afford the discounted rate offered, please speak with your counselor to determine if other arrangements can be made.*

In addition to weekly appointments, we charge our regular rate for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time plus travel time and expenses even if we are called to testify by another party.

Joe Martino Counseling (and most of the therapists associated with Joe Martino Counseling) charges $1,500 a day for testifying in court. If you request our therapist to testify in court, you will need to pay this fee up front and understand they can only testify regarding the client after

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they have signed a release form. In the case of couples or families, everyone over the age of fourteen will have the same protection. Because of this, everyone will need to sign a release form.

Please note that full payment is due at the time services are received. For any delinquent account, it is our policy to temporarily cease administering services until such a time as client makes delinquent payments.

INSURANCE. Because of our commitment to quality of care and our clients' privacy, Joe Martino Counseling accepts all of the insurances that agree to work with us. If we cannot take your insurance, (because they refuse to participate with us) we will work with you to come to a reasonable solution for payments to the best of our ability. If we cannot come to an agreement, we will give you a referral list of at least three counselors at your request.

RECORDING OF SESSIONS. For supervisory issues and client/counselor protection, Creative Solutions records all of our client sessions. These recordings are kept confidential and secure, and in most cases, we destroy these recordings within thirty-six months.

CONTACTING US. We are often not immediately available by telephone. If we are unavailable, our telephones are answered by confidential voice mail that we monitor frequently. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

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CONFIDENTIALITY POLICY

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to law. However, there are limits to such communication some of which are mandated by state law. It is very important that you and those seeking counseling with you carefully read and understand the following limits of confidentiality.

Duty to Warn. Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:

1. The person or the family of the person who is likely to suffer the results of harmful behavior.
2. The family of the client who intends to harm him/herself or someone else.
3. Associates, friends of those threatened, or making threats.
4. Law enforcement and medical emergency officials.

Child Abuse. Michigan state law mandates the reporting of incidence of suspected incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies.

"Dependent Adult" and Elderly Abuse. Michigan law requires the incidence of "dependent adult" or elderly physical abuse reported to your counselor must also be reported to Michigan authorities.

Professional Misconduct. Professional misconduct by a healthcare professional must be reported by other healthcare professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released to substantiate disciplinary concerns.

Court Orders. Healthcare professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Case Evaluation. In order to ensure the best treatment possible for each client, Creative Solutions Counseling staff does consult with each other regarding cases. This is traditional in both out-patient and in-patient counseling facilities and is referred to as "case conference" or "peer review." If you have any concerns regarding this practice, please notify your therapist.

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Please be sure that you have read the above very carefully. If you are not sure that you fully understand any of the above areas of confidentiality limitations, please ask your counselor before you sign below. I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding the limits of confidentiality.

Signature: _____ Date: _____

Signature: _____ Date: _____

As part of our commitment to total quality care, we would like to be able to co-ordinate with your primary care physician when appropriate. Please read the items below carefully so that we can provide the best care possible. If you agree simply check that box and sign.

- ☐ I give permission for a letter to be sent to my doctor stating that I have been seen here and are how my progress is going. (This is especially helpful if your doctor referred you to us).
- ☐ I give permission for the release of all treatment information as deemed necessary by my therapist to my primary doctor for the coordination of all care.
- ☐ I do not give permission for any communication between my doctor and my therapist at this time. If my therapist would like to communicate with my doctor, I would prefer that they discuss this with me first.

Printed Name: _____ Signature: _____

Physicians Name:_____

Phone number: _____

City:_____

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Agreement to pay for services not covered by third party

By signing this agreement you consent to the fact that you are responsible to pay for all services covered. If you are using third party insurance as your primary means of payment, you are still responsible for any portion that they do not pay. If you cancel for an appointment inside the 24-hour window, insurance will not pay for that and you will be responsible to pay that amount before your next session. If your insurance company decides to not pay for a session, you will be responsible for the payment of that session. (Initials_____ _____ _____ _____).

Regarding Outstanding Balance

Please fill out the below information. By filling out this information and by signing this paper you agree that we can debit the provided card below, plus a five dollar ($5.00) processing fee in the event that you fail to make a payment. We will attempt to contact you twice, after which we will debit your card. Also, this card can be debited if you fail to show up and fail to make payment arrangements with our office.

Card type: _____

Card number _____

Exp. Date _____ CV code: _____Zip Code associated with the card: _____

Please print your name and sign below:

Print Name:

_____

Signature:

_____

Date: _____

This agreement for counseling is between _____ (print name)

and _____ (print name of counselor).

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Agreement to Counseling

□ I, the undersigned, acknowledge that I have received and read this counseling agreement & understand the above information, and agree to voluntarily receive and participate in the counseling process on that basis. I fully understand the responsibility of this agreement.

□ I, the undersigned, authorize the audio and or video recording of sessions.

□ I, the undersigned, hereby will be paying for services at the close of each session.

□ I, the undersigned, give permission to bill my insurance company if that is applicable to my care with Joe Martino Counseling, and Creative Solutions Counseling

□ I, the undersigned, understand that if a payment plan has not been established and when charges have not been paid within 30 days of the due date. I agree to pay for any charges for each returned check. The charge for a returned check is $35.

□ I, the undersigned, understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A FULL CHARGE WILL BE MADE. I will be fully responsible for such charges.

_____ _____

Client, Parent or Guardian's Name (Please Print) Date

_____ _____

Client, Parent or Guardian's Name (Please Print) Date

_____ _____

Client, Parent or Guardian's Name (Please Print) Date

_____ _____

Client, Parent or Guardian's Name (Please Print) Date

_____ _____

Client, Parent or Guardian's Name (Please Print) Date

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Release of Information:

Please read this document carefully. By signing below you are agreeing to confidential information about you and your sessions being released to a third party. You do not have to do this and we will never release your information without your express, written consent, unless compelled to do so by law and in accordance with our confidentiality policy that you agreed to when you began your sessions with us.

☐. I give permission for the release of information from my file to the following parties. Name, address, and phone number please. (If necessary, you can use extra paper).

_____
_____
_____
_____
_____

☐. The nature of the material I would like have disclosed is: _____

_____
_____
_____
_____

☐. Please mail the summary to the above party.
☐. Please email the summary to the above party.
☐. I will pick up the material and deliver it myself to the parties as I see fit.
☐. I would like for _____ to be able to call you on the phone.
☐. I understand that all phone calls by interns are monitored by their on site supervisor
☐. I realize there is minimum $35 fee and a maximum $65 fee for this service.

Print name: _____

Sign name: _____

Date: _____

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