Glimpses of Hope
CHRISTIAN COUNSELING AND PLAY THERAPY

Glimpses of Hope, LLC
Kristine McPeek, M.A., LPC, NCC, RPT-S
14147 Robert Paris Ct.
Chantilly, VA 20151
cell (703) 869-8326

CONFIDENTIAL CLIENT INTAKE FORM

Client Contact Information: ***Client is a minor ____ (complete italicized portions also)*** ⬅

Name: _____ Today's date: _____

Sex: Male ___ Female ___ Date of birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (C) _____ (H) _____ (W) _____

May we leave a message? ____ E-mail: _____

Preferred method of communication: _____

How did you hear about Glimpses of Hope, or Kristine McPeek?

_____

Emergency Contact Information:

Emergency contact name: _____

Phone number: _____Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of individual completing form: _____ ***Relationship:*** _____

Christian Counseling Information:

Do you regularly attend a church, synagogue, or other religious institution? Yes___ No____

If yes, where do you attend?_____

Would you like Biblically-based counseling: Yes____ No____ Unsure____ Discuss_____

Culture and Occupation/*School*:

Are there any cultural, ethnic, spiritual, religious or other issues your therapist should know?

If yes, please describe: _____

What is your current occupation? _____

Level of satisfaction with occupation/***school***? _____

Name of School: _____ ***Grade:***_____

List any school (occupational) ***concerns:***_____

_____

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Interests:

Describe areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?	When it changed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family/Social Support System:

Current marital status ***(Parent's status:)*** Single____ Engaged____ Married____
Separated ____ Divorced___ Widowed___ Partner____ In a relationship____

If engaged, married, separated, divorced, or widowed, for how long? _____

Number of previous marriages for you: _____ For your spouse: _____

If married, spouse's name: _____ Age: _____

Is your spouse ***(other parent)*** supportive of you seeking counseling? Yes___ No___ Unsure___
Spouse is Unaware___

Briefly describe your spouse/***parents*** (supportive, outgoing, angry, controlling, avoidant, etc.):

_____

Who can you count on for support? _____

Does your family have technology limits? _____

Describe the online/social media boundaries for your family: _____

_____

Early History:

Any history of trauma or mental health concerns for parents: _____

Mother's pregnancy: (health, substances, full term, etc.) _____

Infancy information: (delivery complications, APGAR/health, nursing, birth order)

_____

Early childhood: (developmental milestones, social, health) _____

Any physical or emotional trauma: _____

Other relevant information: _____

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Family/Social Support System (cont.):

With whom are you currently living?

Name	Age	Relationship

List any family members or others who have had a significant effect on your life (positive or negative).

Name	Age	Relationship	How you describe him/her (i.e. anxious, supportive, outgoing, angry, controlling)

List anyone in your family who has struggled with addiction, substance abuse, mental health issues, psychiatric conditions, or hospitalized due to self harm concerns?

Name	Relationship to you	Concern(s)

Please describe how this has impacted you: _____

Have any family members or friends ever attempted or committed suicide? Yes___ No____

If yes, who and when? _____

Check how you generally get along with other people (check all that apply):

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often

___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn

___ Other (specify): _____

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Medical History:

Please list any relevant conditions, illnesses, treatments, surgeries or other health concerns:

_____

Are you currently receiving any medical treatment? Yes____ No____ If yes, please describe:

_____

Please list all current medications and the reason for taking them, both prescribed and OTC. (List even if you seldom use, or take only as needed.)

Name of Medication Dose Reason for Taking Side Effects (if any)

_____

_____

_____

_____

Are you taking these medications according to the doctor's orders? Yes____ No____

If no, please explain: _____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level ____ Disposition
____ Energy level ____ Nervousness ____ Weight ____ Tension ____ Physical activity

Describe changes in areas which you checked above:

_____

_____

Date and outcome of last physical exam: _____

List any food or environmental allergies: _____

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Counseling History:
If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back of this sheet if necessary.)

Therapist's Name or Program Reason for Counseling Dates

_____

_____

_____

Presenting Concerns and Goals:

Please describe the event(s)/stressor prompting you to counseling?

(i.e. issues/ problems, symptoms, length of time, etc. Use the back if necessary.):

_____

_____

_____

_____

_____

What are your goals for counseling?

1) _____

2)_____

3)_____

4)_____

Are you currently experiencing any suicidal thoughts? Yes____ No____

Have you experienced suicidal thoughts in the past? Yes____ No____

Have you attempted suicide in the past? Yes____ No____

If yes, please describe when, where, and what actions taken: _____

_____

Are you currently experiencing any violent or homicidal thoughts? Yes____ No____

Other? Please explain:_____

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Current/Recent Symptoms:

Check **only** the categories that you are or have experienced. Then circle **how** distressing it is:

	very minimally distressing			moderately distressing			extremely distressing		
____ Aggression	1	3		5		7	9		+
____ Alcohol Dependence	1	3		5		7	9		+
____ Anger	1	3		5		7	9		+
____ Antisocial Behavior	1	3		5		7	9		+
____ Anxiety	1	3		5		7	9		+
____ Apathy	1	3		5		7	9		+
____ Avoiding people	1	3		5		7	9		+
____ Bad dreams	1	3		5		7	9		+
____ Bullying/Bullied	1	3		5		7	9		+
____ Career choices	1	3		5		7	9		+
____ Chest pain	1	3		5		7	9		+
____ Chronic pain	1	3		5		7	9		+
____ Controlling	1	3		5		7	9		+
____ Controlled by others	1	3		5		7	9		+
____ Compulsive behaviors	1	3		5		7	9		+
____ Cyber addiction	1	3		5		7	9		+
____ Depression	1	3		5		7	9		+
____ Disobedience (willful)	1	3		5		7	9		+
____ Disrespectfulness	1	3		5		7	9		+
____ Distractibility	1	3		5		7	9		+
____ Dizziness	1	3		5		7	9		+
____ Drug dependence	1	3		5		7	9		+
____ Eating disorder	1	3		5		7	9		+
____ Elevated mood	1	3		5		7	9		+
____ Emotional abuse	1	3		5		7	9		+
____ Family problems	1	3		5		7	9		+
____ Fatigue/Lack of energy	1	3		5		7	9		+

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Current/Recent Symptoms Cont'd

	very minimally distressing				moderately distressing				extremely distressing		
____ Feeling worthless	1	·	3	·	5	·	7	·	9	·	+
____ Financial problems	1	·	3	·	5	·	7	·	9	·	+
____ Frequent crying	1	·	3	·	5	·	7	·	9	·	+
____ Gambling	1	·	3	·	5	·	7	·	9	·	+
____ Gender identity issues	1	·	3	·	5	·	7	·	9	·	+
____ Grief	1	·	3	·	5	·	7	·	9	·	+
____ Hallucinations	1	·	3	·	5	·	7	·	9	·	+
____ Hearing voices	1	·	3	·	5	·	7	·	9	·	+
____ Heart palpitations	1	·	3	·	5	·	7	·	9	·	+
____ High blood pressure	1	·	3	·	5	·	7	·	9	·	+
____ Hopelessness	1	·	3	·	5	·	7	·	9	·	+
____ Impulsivity	1	·	3	·	5	·	7	·	9	·	+
____ Indecisiveness	1	·	3	·	5	·	7	·	9	·	+
____ Irritability	1	·	3	·	5	·	7	·	9	·	+
____ Judgment errors	1	·	3	·	5	·	7	·	9	·	+
____ Lack of appetite	1	·	3	·	5	·	7	·	9	·	+
____ Legal matters	1	·	3	·	5	·	7	·	9	·	+
____ Loneliness	1	·	3	·	5	·	7	·	9	·	+
____ Loss of control	1	·	3	·	5	·	7	·	9	·	+
____ Low self-esteem	1	·	3	·	5	·	7	·	9	·	+
____ Marital problems	1	·	3	·	5	·	7	·	9	·	+
____ Memory impairment	1	·	3	·	5	·	7	·	9	·	+
____ Mood shifts	1	·	3	·	5	·	7	·	9	·	+
____ Night sweats	1	·	3	·	5	·	7	·	9	·	+
____ Obsessive thoughts	1	·	3	·	5	·	7	·	9	·	+
____ Overeating	1	·	3	·	5	·	7	·	9	·	+
____ Panic attacks	1	·	3	·	5	·	7	·	9	·	+
____ Parenting problems	1	·	3	·	5	·	7	·	9	·	+
____ Phobias/fears	1	·	3	·	5	·	7	·	9	·	+
____ Physical abuse	1	·	3	·	5	·	7	·	9	·	+

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Current/Recent Symptoms Cont'd

	very minimally distressing			moderately distressing			extremely distressing		
____ Poor concentration	1	· 3 ·	5	· 7 ·	9	· +			
____ Pregnancy(ies)	1	· 3 ·	5	· 7 ·	9	· +			
____ Racing thoughts	1	· 3 ·	5	· 7 ·	9	· +			
____ Recent death(s)	1	· 3 ·	5	· 7 ·	9	· +			
____ Recurring thoughts	1	· 3 ·	5	· 7 ·	9	· +			
____ Relational problems	1	· 3 ·	5	· 7 ·	9	· +			
____ See things others don't	1	· 3 ·	5	· 7 ·	9	· +			
____ Sexual addiction	1	· 3 ·	5	· 7 ·	9	· +			
____ Sexual difficulties	1	· 3 ·	5	· 7 ·	9	· +			
____ Sexual abuse	1	· 3 ·	5	· 7 ·	9	· +			
____ Shyness	1	· 3 ·	5	· 7 ·	9	· +			
____ Sick often	1	· 3 ·	5	· 7 ·	9	· +			
____ Speech problems	1	· 3 ·	5	· 7 ·	9	· +			
____ Spiritual problems	1	· 3 ·	5	· 7 ·	9	· +			
____ Stress	1	· 3 ·	5	· 7 ·	9	· +			
____ Suicidal thoughts	1	· 3 ·	5	· 7 ·	9	· +			
____ Thoughts disorganized	1	· 3 ·	5	· 7 ·	9	· +			
____ Trembling	1	· 3 ·	5	· 7 ·	9	· +			
____ Trouble sleeping	1	· 3 ·	5	· 7 ·	9	· +			
____ Unwanted memories	1	· 3 ·	5	· 7 ·	9	· +			
____ Verbal abuse	1	· 3 ·	5	· 7 ·	9	· +			
____ Withdrawing	1	· 3 ·	5	· 7 ·	9	· +			
____ Work stress	1	· 3 ·	5	· 7 ·	9	· +			
____ Worrying	1	· 3 ·	5	· 7 ·	9	· +			
____ Other (Specify):	1	· 3 ·	5	· 7 ·	9	· +			

Please explain any of the previous symptoms in detail or anything else you would like to disclose to your counselor: _____

_____

_____

_____

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Client's Signature _____ Date _____

Parent/Guardian Signature _____ ***Date*** _____

(Name, Relationship) _____

Additional Signature (if mixed custody) _____

(Name, Relationship) _____

Additional Notes:

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PRIVACY POLICY

Our commitment to your privacy

We are dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep this protected health information (PHI) confidential. This notice describes how we use and safeguard your information.

We will use protected health information about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which the law calls health care operations. If we or you want to use or disclose your information for any other purpose, such as coordinating care with your doctor, we will discuss this with you and ask you to sign an Authorization form to allow this.

In some legal situations we may be required to use or share your health information without prior authorization, such as:

1. When there is a serious threat to the health and safety of you, another individual, or the public.
2. Some lawsuits and legal or court proceedings: if law enforcement or court officials require us to do so.
3. For Workers Compensation, Third-Party billing/insurance, and similar benefit programs.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way that is more private for you. For example, you can ask us to call your home, not work, to schedule or cancel appointments.
2. You have the right to ask us to limit what we tell family members and friends who are involved in your care, or the payment of your care. If we believe there are clinical or legal reasons why we cannot honor your request, we will discuss this with you.
3. You have the right to look at the health information we have about you. This includes identifying information and billing records, but does not include notes of psychotherapy sessions. You can get a copy of these records, but we may charge you for preparing the copies. If you wish to look at your health information, or receive copies, please contact your therapist.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make changes, called amending, to your health information. You must put this request in writing, include the reasons you want to make the changes, and sent it to our office.
5. You have the right to receive an accounting of any disclosures of your protected health information we have made since this notice went into effect.
6. You have a right to a copy of our current privacy practices. If we change this notice, we will post the new version in a prominent location, and you can request a copy from your therapist.
7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a written complaint with our Clinical Supervisor and with the Secretary of the Department of Health and Human Services. Filing a complaint will not change the care we provide to you in any way.
8. You are entitled to a copy of these privacy practices.

Acknowledgement of Privacy Practices

I, _____, have read and received a copy of the notice of privacy
(Please print name) practices and policies on _____.
Date

_____ _____

(Signature of client or ***legal representative/guardian***) Date

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RELEASE OF INFORMATION

I, _____, hereby authorize an exchange of information between my
Print Name

(*or my child*'s*) therapist _____ and the following named person(s)and/or
Print therapist's Name

organization: _____
List name(s) of Individual(s)/Organization(s) to whom information may be released

_____

Phone Number and Address: _____

_____

Child's Name (if a minor):_____

Restrictions on material or information to be disclosed: _____

This release is open-ended_____ or expires_____ on _____.

I authorize the therapist or organization listed to disclose any information that could be relevant and beneficial for my counseling/psychotherapy with Glimpses of Hope, including protected health information.

I am aware that both parties will maintain confidentiality according to accepted standards of the profession. These include providing only that information that will assist in the client's care by all parties.

Please read the following important information:

- Upon expiration of this authorization, no more information can be disclosed, or used, unless I sign a new authorization.
- I can revoke this authorization in writing. My revocation will be effective immediately after I supply it to my counselor. I may also send my written revocation to the person(s) or organization that is to disclose the information in this authorization.
- I may refuse to authorize my counselor to seek external information pertaining to my psychotherapy and still be eligible to receive counseling from him or her.
- If I authorize discloser of my information any individual who is not a health care provider or health plan covered by federal privacy regulations, that person will not be subject to HIPPA regulations.
- I can request a copy of any written information shared under this authorization, though there may be a fee to prepare the copies. I may receive a copy of this authorization for my personal records.

My signature below indicates I authorize this release of information for professional consultation by my counselor.

_____ _____

Signature Date

_____ _____

In case of minor, ***signature of parent/guardian*** Date