Jennifer Michaels Therapy
www.jemichaels.com | jemichaels@email.com | (843) 514-2848

Confidential Client Intake Form

GENERAL INFORMATION

Last Name: _____ First: _____ Middle Initial: _____
Preferred Name: _____ Birth Date: ___ / ___ / ___
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell: (____) _____
Any phone instructions (re: msgs, etc): _____
Email #1: _____
Email #2: _____
Emergency Contact: _____ Phone: (____) _____
Relationship: _____
Parent/Guardian (if under 18): _____
Referred by / How you learned of me and JMT: _____
Reason for referral: _____

FAMILY INFORMATION

Relationships:
Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Cohabiting__
Parents:
Mother: Living ___ Age: ___ Deceased ___
Father: Living ___ Age: ___ Deceased ___
Siblings:
Number of Brothers: [ ] Names an ages_____
Number of Sisters: [ ] Names an ages_____
Only Child ___
Names and ages of your children:

Are any of your children deceased? _____
Household members not listed above: _____

EMPLOYMENT / EDUCATION INFORMATION

Full-time employee ___ Full-time at home ___ Part-time employee ___ Unemployed ___
Place of employment: _____
Length of employment: _____
Type of work you do: _____

Highest level of education completed:
High School ___ College degree ___ Graduate degree ___
Professional Training ___ Other: _____

MEDICAL / PSYCHOLOGICAL HISTORY
Name of your physician: _____ Phone: (____) _____
When was your last medical examination? _____
Are you suffering any physical illnesses or symptoms at this time?

List major surgeries or illnesses in the last five years:

List current medications:

Are there chemical abuse issues in your family? Yes ___ No ___
If clean/sober, for what length of time? _____
When? _____ Name of helping agency: _____
Have you received psychotherapy or counseling in the past year? Yes ___ No ___
When? _____
Name of treating therapist: _____ Where? _____
Type of problem: _____

SPIRITUALITY
Religious / Denominational preference: _____
Your church/synagogue: _____ Member? _____
Pastor / Priest / Rabbi: _____
Attendance: Regular ___ Occasional ___ Seldom ___ Never ___

Please check any questions you would answer "yes" to:
___ Do you have thoughts of harming yourself or others?
___ Are thoughts of harming yourself or others a frequent occurrence?
___ Do you dwell on these thoughts and wonder if you can control them?
___ Have you sought professional help because of these thoughts or feelings?

Please check any words that describe you at this time:
___ Anger ___ Anxiety ___ Chronic fear
___ Conflicts at work ___ Depression ___ Financial problems
___ Grief ___ Guilt feelings ___ Health issues
___ Irrational fears ___ Loneliness ___ Loss of faith in God
___ Loss of hope ___ Loss of meaning in life ___ Loss of work/job
___ Marriage problems ___ Nervousness ___ Rage
___ Relationship to parents ___ Relationship to children ___ Self-esteem
___ Sexual problems ___ Stress ___ Substance abuse
___ Suicidal feelings ___ Religious doubts ___ Other: _____

What are you hoping to achieve with counseling_____
_____
_____

Client's Signature: _____ Date: _____
Therapist's Signature: _____ Date: _____

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HIPPA Authorization for Use of Disclosure of Protected Health Information

I authorize Jennifer Michaels and/or her administrative and clinical staff to (check all that apply):
___ use the following protected health information, and/or
___ disclose the following protected health information between Jennifer Michaels Therapy and/or its employees with:

Types of information to be released:
___ Dates of service
___ Origin of information
___ Symptoms
___ Diagnosis
___ Level of detail to be released: _____
___ Type of service
___ Results of testing
___ Mental functioning
___ Prognosis

This protected health information is being used or disclosed for the following purposes:
___ At the request of the individual, parent, or guardian
___ Continuity of care

_____I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:
Jennifer Michaels Therapy
207 Simmons Street, Mt. Pleasant
jennifer@jemichaels.com
_____I understand that a revocation is not effective to the extent that Jennifer Michaels has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
_____I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Jennifer Michaels will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except for:

1. If my treatment is related to research, or
2. If health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will not result in direct or indirect remuneration to Jennifer Michaels from a third party.

Signature of Patient _____**Date:** _____
Print Name of Patient: _____

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Pre-Licensed Therapist Disclosure, Informed Consent, and Recording Authorization Form

You are receiving counseling services from Jennifer Michaels, a graduate student in the Clinical Mental Health Counseling program at the University of the Cumberlands. Jennifer is currently completing her practicum/internship and is practicing under supervision as part of her training. She has completed graduate-level coursework in ethics, counseling techniques, diagnosis, and theories and is receiving regular supervision from both her site and university supervisors.

Site Supervisor
Name: Caroline Ilderton, MA, LPC
Email: caroline@carolineielton.com
Phone: 843-881-9500

Supervision and Confidentiality
Your sessions may be discussed with Jennifer's supervisors to ensure quality of care and support her training. Supervisors are bound by the same confidentiality standards.
All services are confidential, except under the following circumstances:

- You are at risk of harming yourself or someone else.
- There is suspected abuse or neglect of a child or vulnerable adult.
- A court orders the release of your records.
- You give written permission to share information.

Counseling Relationship and Client Rights
Counseling is a collaborative process. Jennifer will work with you to identify goals and explore thoughts, emotions, behaviors, and challenges.

You have the right to:

- Be treated with respect.
- Receive ethical and confidential care.
- Refuse or stop counseling at any time.
- Ask questions about your treatment.

Consent to Record Sessions (if applicable)
If you agree, your sessions may be recorded for educational supervision. Recordings will be used only for training, stored securely, and destroyed after review. Your identity will remain confidential.
Check one:
[ ] I consent to session recordings.
[ ] I do not consent to session recordings.

Optional:
[ ] I consent to photos of expressive therapy work (such as sand trays or artwork) being used for supervision or educational purposes. No copies will be retained by the counselor.

Acknowledgment and consent
I understand that counseling will be provided by a counselor-in-training under professional supervision. I have read and understand this form and give my consent to receive services from Jennifer Michaels.

Client Name:_____ Client Signature: _____
Date:_____

Parent/Guardian Signature (if applicable):_____ Date_____

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Financial Agreement and Credit Card Consent

All clients are required to have a valid credit card on file. This card may be charged for scheduled sessions, late cancellations, or missed appointments, unless other payment arrangements have been made in advance.

Sessions are 50, 80, or 110 minutes in length, depending on what you schedule. Payment is due at the time of service. If your card is declined or payment is returned for any reason, you are responsible for any fees charged by the bank or card processor.

If you need to cancel or reschedule your appointment, you must provide at least 24 hours' notice. If notice is not received at least 24 hours in advance, your credit card will be charged the full fee for the missed session.

By signing below, you agree to:

- Keep a valid credit card on file
- Allow your card to be charged for scheduled sessions and missed appointments
- Accept financial responsibility for all services provided

Cardholder name: _____
Credit card last 4 digits (for reference): _____
Signature: _____
Date: _____

Parent/Guardian Signature (if applicable):_____ Date_____

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Holistic Therapy Disclosure and Client Preferences Form

With over 20 years of experience in integrative healing and wellness, combining clinical mental health training with spiritual life coaching, energy healing, mindfulness, and body-mind awareness practices.

I hold a B.S. in Art Therapy and am completing my M.A. in Clinical Mental Health Counseling, currently under the supervision of Caroline Ilderton, MA, LPC. In addition to my academic training, I am certified in yoga, Reiki, hypnosis, vegan health coaching, Akashic records, and life coaching, and I have decades of experience in meditation and spiritual wellness.

My sessions are tailored to meet the needs of each client and may flow between evidence-based holistic therapy, intuitive guidance, energy work, and meditative practices. You are welcome to focus solely on one approach or allow your sessions to evolve naturally based on your needs.

Please take a moment to let me know your preferences:

1. What services are you interested in exploring (check all that apply)?
   [ ] Holistic therapy
   [ ] Spiritual life coaching
   [ ] Energy healing (Reiki, intuitive energy work)
   [ ] Meditation and mindfulness
2. What session length are you most interested in?
   [ ] 50 minutes
   [ ] 80 minutes
   [ ] 110 minutes
3. How frequently would you like to schedule sessions?
   [ ] Weekly
   [ ] Biweekly
   [ ] Monthly
   [ ] Occasional/as needed
4. Would you like information about packages or memberships? Yes _____ No _____
5. Is there anything you'd like me to know about your goals or preferences for our work together?
   _____
   _____

By signing below, you acknowledge that you understand Jennifer Michaels offers holistic services that may blend clinical counseling techniques with spiritual, intuitive, and energy-based practices. You may request that your sessions focus on or exclude specific modalities at any time.

Client Name:_____
Signature:_____Date:_____

Parent/Guardian Signature (if applicable):_____ Date_____

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Emergencies, Supervision, Social Media Consent Agreement

Emergency and Crisis Information

I do not provide crisis or emergency services. If you are in danger or experiencing a mental health emergency, please call 911, go to your nearest emergency room, or contact the National Suicide & Crisis Lifeline by calling or texting 988.

Supervision and Case Review

As a graduate student in Clinical Mental Health Counseling, I am a counselor-in-training and receive supervision as part of my practicum and internship. Your case may be discussed with my site supervisor, Caroline Ilderton, MA, LPC, as well as my university faculty supervisor. These discussions are conducted for the purpose of supporting your care and my professional development. All supervisors are bound by the same confidentiality and ethical guidelines, and identifying details are minimized whenever possible.

Counseling Student Disclosure

I am currently completing my counseling training at the University of the Cumberlands. I do not diagnose mental health disorders or bill insurance. My services are supervised and part of my graduate education.

Social media and Communication Boundaries

To protect your privacy, I do not connect with clients via social media. Please use phone or email for any communication related to sessions or scheduling.

Dual Relationships

Because I am involved in the local wellness and healing community, we may cross paths in public or in other settings. I will never approach or acknowledge you without your invitation. Your privacy will always be respected.

By signing below, you acknowledge that you have read and understand this agreement and give your informed consent to engage in holistic therapy services with Jennifer Michaels.

Client Name:_____
Signature:_____
Date:_____

Parent/Guardian Signature (if applicable):_____ Date_____

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Client Rights, Telehealth Consent, and Communication Policy

Client Rights & Responsibilities

As a client of Jennifer Michaels Therapy, you have the right to:

- Be treated with respect, dignity, and compassion.
- Ask questions at any time about the nature of services being offered.
- Decline or discontinue services at any time, without judgment.
- Request referrals for additional or alternative support.
- Expect that your privacy will be respected and your information handled with care.
- Collaborate in setting goals and shaping your experience of therapy.

You also have the responsibility to:

- Show up on time for scheduled sessions or provide notice if you need to cancel.
- Engage in the process with honesty and openness at your own pace.
- Let me know if something isn't working for you in our work together.

Telehealth Informed Consent

If you choose to receive therapy via phone or video, please read and acknowledge the following:

- I understand that telehealth services are conducted through a secure platform but may carry risks related to technology or privacy.
- I agree to create a quiet, private space for my sessions and understand I am responsible for my environment during telehealth services.
- I understand that telehealth is not appropriate for all clinical situations, and I may be referred to in-person services if needed.
- I understand that if technology fails during a session, we may continue by phone or reschedule if needed.
- I understand that I should not use telehealth if I am experiencing a mental health emergency, and that I will call 911 or go to the nearest emergency room if needed.

File Retention & Communication Policy

Client records are stored securely and are accessible only to Jennifer Michaels and her clinical supervisor as part of her counselor training. These records may include intake paperwork, progress notes, and supervisory documentation.
Email is not considered a confidential means of communication. It is used for scheduling or administrative purposes only. Please do not share sensitive or therapeutic information by email.
By signing below, I acknowledge that I have read and understood my rights as a client, the terms of telehealth services, and the practice's approach to communication and recordkeeping.

Client Name:_____
Signature:_____
Date:_____

Parent/Guardian Signature (if applicable):_____Date:_____