

**Center for Integrative Medicine**  
**Holli Richey, MS, MSW, MAT**

1100 East 3rd Street, Suite G100  
 Chattanooga, TN 37403  
 Telephone: (423) 643-2246 ÉFax (423) 643-2030

**Counseling Notifications and Releases**

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff.

Listed below are notices that outline certain responsibilities of ours, and yours.

***Please read them carefully and sign where indicated that you have read each statement.***

**General Consent for Treatment**

Holli Richey, LMSW, (license number 9340) looks forward to providing you with counseling; she needs your permission before proceeding with the therapeutic relationship. As a licensed master of social work (LMSW), Holli practices within the scope of practice defined by the Tennessee Licensing Board for licensed masters-level social workers, and follows the code of ethics defined by the National Association of Social Workers. The Tennessee Licensing Board requires LMSWs to practice under the regular supervision of a licensed clinical social worker (LCSW) for a minimum of two years. While Holli works with you as a counselor, she will discuss your treatment with her LCSW supervisor.

**Privacy Policy**

As your counselor, I want you to understand that everything you tell me is confidential. All client records are strictly confidential. Both Holli and the supervisor adhere to the same strict guidelines of confidentiality. Client records can only be shared if subpoenaed within a court of law. By law, client confidentiality is maintained unless the client provides information stating his or her intention is to cause harm to him or herself or to another person.

**I give general consent to be treated, and I acknowledge that I have been informed about the privacy of my counseling records**

\_\_\_\_\_ Date: \_\_\_\_\_

**PRIVACY RESTRICTION**

I will not discuss your records with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

**I understand the above statement and (check one box below):**

I do not mind that my counseling records are shared with my parent/guardian or partner at anytime.

I want my counseling records to remain confidential. My information should **NOT** be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Treatment EXCEPTION:** If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

**Financial Policy**

Acceptable methods of payment for counseling is with cash, check or credit card. Currently, insurance will not reimburse counseling provided by LMSWs.

**I acknowledge it is my responsibility to ensure payment of fees for services provided by the counselor at the practice.**

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient / Patient's representative

**CENTER FOR INTEGRATIVE MEDICINE**  
**PATIENT DEMOGRAPHIC FORM**  
**(PLEASE PRINT)**

Primary Provider seen in our office:

\_\_\_\_\_

**PATIENT INFORMATION**

Legal First Name: \_\_\_\_\_ Legal Last Name: \_\_\_\_\_

Middle Name \_\_\_\_\_ Name you prefer to go by \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: (please circle) Male Female

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

Secondary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

SS# \_\_\_\_\_ Email Address \_\_\_\_\_

**Our monthly newsletter provides clients with healthy recipes and current research on integrative health.  
 Would you like to receive a copy of our monthly newsletter via email? YES NO**

Relationship Status (circle): single cohabitating married divorced widowed

Partner's Full Legal Name \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact (someone not living in your household)

Contact Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_

Person responsible for bill if patient is a minor: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different):

\_\_\_\_\_

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## **Notifications and Releases for "Minors"**

We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. ***Please read them carefully and sign where indicated that you have read each statement.***

### **General Consent for Treatment**

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**I give general consent to be treated, and I acknowledge that I have been informed about the privacy of my counseling records.**

\_\_\_\_\_ Date: \_\_\_\_\_  
 Patient / Patient's representative

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\_\_\_\_\_ Date: \_\_\_\_\_  
Patient / Patient's representative

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\_\_\_\_\_ Date: \_\_\_\_\_  
Patient / Patient's representative

**Counseling Intake Form**  
**Holli Richey, MS, MSW, MAT**  
 1100 E. Third St. \* Suite G-100 \* Chattanooga, TN 37403  
 Tel: (423) 643-2246 \* FAX: (423) 643-2030

**Client's name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Primary reason(s) for seeking services today:

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Check behaviors and symptoms that occur more often than you would like them to:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aggression             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Panic Attacks         |
| <input type="checkbox"/> Alcohol dependence     | <input type="checkbox"/> Flashbacks          | <input type="checkbox"/> Phobias/Fears         |
| <input type="checkbox"/> Anger                  | <input type="checkbox"/> Grief               | <input type="checkbox"/> Poor judgment         |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Self-Esteem Problems  |
| <input type="checkbox"/> Chronic Pain           | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Sexual Difficulties   |
| <input type="checkbox"/> Compulsive behavior    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep problems        |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Social Withdrawal     |
| <input type="checkbox"/> Cyber addiction        | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Suicidal thoughts     |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation         | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Distractibility        | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Unresolved Trauma     |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Drug dependence        | <input type="checkbox"/> Mood swings         | <input type="checkbox"/> Other (specify):      |
| <input type="checkbox"/> Eating disorder        | <input type="checkbox"/> Obsessive Thoughts  |  |

**Marital Status/Current Living Situation**

Single  Married  Living with significant Other  Separated  Divorced  Widowed

Assessment of current relationship (if applicable):  Good  Fair  Poor

Spouse/Partner \_\_\_\_\_ Age \_\_\_\_\_

Children: how many? Biological  adoptive  fostered  step

Genders: M  F

**Employment**

Please check employment status:

employed full-time  employed part-time  unemployed  disabled  retired

If currently employed, please list job information below:

Employer Job Title How long there?

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**THIS FORM IS CONFIDENTIAL AND NOT AUTHORIZED FOR RE-RELEASE**

**Counseling/Prior Treatment History**

Have you had any prior professional counseling or psychiatric treatment? \_\_\_ Yes \_\_\_ No

If yes, please list most recent treatment episodes, who treated you, and outcome below:

*Approximate Treatment Dates Treatment Provider/Facility Outcome*

\_\_\_\_\_

\_\_\_\_\_

**Medication and Chemical Use History****Current Prescribed Medications Dose Frequency Purpose Side effects**

Have you ever been treated for alcohol or drug dependence/abuse? \_\_\_ Yes \_\_\_ No

Have you ever felt like you should cut down on alcohol or other drug use? \_\_\_ Yes \_\_\_ No

Has a friend or relative ever discussed concerns about your drug use? \_\_\_ Yes \_\_\_ No

Have you ever felt guilty about your drinking or drug use? \_\_\_ Yes \_\_\_ No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? \_\_\_ Yes \_\_\_ No

Is there a history of problems with alcohol or drug use in your family? \_\_\_ Yes \_\_\_ No

Please note any current or past use of the following substances:

	Amount	Frequency	Age of First Use	Last Use	48 hours? 30 days?	
					Yes No	Yes No
Caffeine	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____
Opioids/Narcotics _____	_____	_____	_____	_____	_____	_____
Amphetamines _____	_____	_____	_____	_____	_____	_____
Cocaine/Crack _____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____
LSD/Shrooms/PCP _____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____

**Medical/Physical Health**

List any current health concerns: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician's Name and Phone Number: \_\_\_\_\_

Last physical exam: Date \_\_\_\_\_ Reason \_\_\_\_\_

Results \_\_\_\_\_

Last doctor's visit \_\_\_\_\_

**Family History/Development**

List any pertinent family history of medical, mental health, or substance abuse problems:

\_\_\_\_\_

Significant Family Members (e.g., parents, siblings, step-relatives, half-relatives.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Living? Living with you? Yes No Yes No

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Living? Living with you? Yes No Yes No

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Living? Living with you? Yes No Yes No

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ Living? Living with you? Yes No Yes No

Are there unusual or traumatic circumstances that affected your development? Yes \_\_\_ No

If Yes, please describe: \_\_\_\_\_

Have you ever been a victim of sexual, physical, emotional, or verbal abuse? \_\_\_ Yes \_\_\_ No

**Education**

Fill in all that apply:

High school grad/GED \_\_\_\_\_

Vocational: \_\_\_\_\_ Number of years: \_\_\_\_\_ Graduated: Yes No Major: \_\_\_\_\_

College: \_\_\_\_\_ Number of years: \_\_\_\_\_ Graduated: Yes No Major: \_\_\_\_\_

Graduate: \_\_\_\_\_ Number of years: \_\_\_\_\_ Graduated: Yes No Major: \_\_\_\_\_

Other training: \_\_\_\_\_

Currently enrolled in school? \_\_\_ Yes \_\_\_ No (If yes, where? \_\_\_\_\_)

Special circumstances (e.g., learning disabilities, gifted):

**Social Relationships**

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

\_\_\_ Affectionate \_\_\_ Aggressive \_\_\_ Avoidant \_\_\_ Fight/argue often \_\_\_ Follower

\_\_\_ Friendly \_\_\_ Leader \_\_\_ Outgoing \_\_\_ Shy/withdrawn \_\_\_ Submissive

Other (specify):

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**Spiritual/Religious**

How important to you are spiritual matters? \_\_\_ Not Little \_\_\_ Moderate \_\_\_ Much

Are you affiliated with a spiritual or religious group? Yes \_\_\_ No

If Yes, describe: \_\_\_\_\_

Would you like your spiritual/religious beliefs incorporated into the counseling? \_\_\_ Yes No

If Yes, describe: \_\_\_\_\_

**Military**

Military experience? Yes No

Combat experience? Yes No

Where: \_\_\_\_\_

Branch: \_\_\_\_\_ Discharge date: \_\_\_\_\_

Date enlisted: \_\_\_\_\_ Type of discharge: \_\_\_\_\_

**Legal**

**Current Status**

Are you involved in any active cases (civil, criminal)? Yes \_\_\_ No

If Yes, please describe and indicate the court and hearing/trial dates and charges:

\_\_\_\_\_  
\_\_\_\_\_

Any additional information that would assist us in understanding your concerns or problems:

\_\_\_\_\_  
\_\_\_\_\_

What are your goals for therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Staff Use**

Therapist's signature/credentials: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Comments/Information pertinent to treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_