**Philip Morrison, LCSW**

**Philip.Morrison.LCSW@protonmail.com**

**Philip-Morrison-LCSW.square.site**

**Initial Intake overview:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Presenting issue (Briefly):** Please describe the reason for reaching out today. Let me know more if there is a specific issue that you are dealing with, as well as any background information on how you, or others, identified there was a “problem,” and what interventions or coping strategies have you already attempted to seek help/guidance in resolving the(se) issues:

**Important facts/themes:** In understanding the presenting issue, there may be other individuals or situations that are important themes to understand. Please help me understand your situation better by listing any details that you feel may be important in getting started. These details may be: Significant other (name, age, when did the relationship start and when did the relationship start to have problems), Career (any special training education, years in the field, other interests/hobbies/activities), Children/relatives (names, ages, relationships and their current role as it relates to the issue(s), Overall health status (any known diagnoses from previous treatment history, whether physical health, mental health, drug and alcohol, developmental milestones, etc.), Social Determinants of Health (these are areas that may be positive strengths or negative concerns that are impacting your ability to carry out daily functions such as access to: food, shelter, clothing, day care, appropriate healthcare, transportation, social/ethnic/racial/gender connections, education/vocational, etc.)

**Goals/Hopes for entering into therapy:** I recognize that individuals usually do not choose to turn to a therapist as their first option or intervention. When people accept that there is an issue that needs intervention, they are most likely to turn to family, friends, or known interventions in an attempt to address the issue. Often, individuals may not even know there is an issue until others repeatedly point it out to them or a sudden event occurs that forces them to seek immediate intervention. For this reason, I acknowledge that you have lived with this issue long before contacting me and have already attempted interventions. As a trained professional, my hope is to give honest, unbiased, and professional feedback to you on your issue, help you see your issue a new way, and help you develop a plan to move forward. Please let me know, in your own words, what you picture as your goal for therapy and if you know any steps you need assistance in getting there:

**Health Insurance Privacy and Portabilty Act (HIPPA):** All healthcare providers are bound by State and Federal confidentiality laws. These laws protect your private health information from being disclosed without your expressed written permission, except when there is a concern of life/death/harm to self or others. Please indicate with initials/signature below if there are any individuals with whom you wish to give permission to speak with me regarding the following specific areas:

**\_\_\_\_\_\_ Confirmation** that you are voluntarily participating in mental health treatment. This may include the frequency and duration of appointments only.

**\_\_\_\_\_\_ Confirmation** that the following individual(s) are part of my “Wellness Plan.” These individuals may be emergency contacts and may be contacted for collaboration with my care as agreed upon:

Contact #1 Contact #2

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I understand that my consent can be withdrawn at any time with advance notice and discussion with my therapist. Additionally, my consent will not be valid for more than 1 year and must be renewed annually as necessary. **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Scheduling/Payment:** It is preferred that appointments are scheduled and confirmed in advance. Appointments are primarily scheduled to be over a telehealth platform, using Doxy.me. A link for each session will be sent in advance of each session. Ability to have a stable internet connection and an environment that is comfortable for you to talk openly is preferred. Scheduling hours are flexible and rescheduling with 24-hour advance notice is preferred to ensure you have the best experience.

Payment for services is expected to be confirmed in advance through one of the approved/agreed upon payment methods. It is in your best interest to ensure payment of services prior to your appointment so that valuable session time is not spent or lost on payment issues. Any issues with payment should be addressed prior to the next session and can result in a termination of services.

Please be mindful of the allotted time limits for sessions. The typical therapy session is a 50-minute session with time at the end for summarizing, goal planning, and scheduling a next appointment as necessary. It is recommended to log in before your scheduled time to test the connection and be placed in the “waiting room.” Homework is a common expectation between sessions, as there is time left at the end of each session to review and reflect what was discussed, as well as potential next steps in the therapeutic process.

By signing, I acknowledge that I have had the opportunity to review my responsibilities in scheduling and payment of services. I have had the opportunity to review any questions or concerns I have and understand that scheduling and payment of services is my responsibility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional resources/information/rights:** As a Licensed Clinical Social Worker, insured and practicing in the State of Pennsylvania, I am bound by all ethical, legal and other obligations to operate a private therapy practice. These laws and rules are updated regularly, so it is best to refer to the State guidelines regarding any areas of concern you may have. Should you have any issues with your treatment services, you are encouraged to speak to these concerns with me directly with no expectation of harm or retribution. My goal is to understand your concerns and provide an honest, unbiased, and professional response to your stated goals and needs. By signing, I acknowledge that I understand I have a right to speak to my therapist if I have any concerns regarding my treatment. I also have a right to seek outside advocacy if my needs are not able to be addressed with my therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crisis Intervention/Services: While my hope and goal is to help you understand how to manage and overcome any current issues, as well as gain a better understanding of past beliefs, experiences, actions that may have led to your current situation, not all issues can be predicted in advance. Additionally, a goal of entering into a therapeutic relationship often involves uncovering past traumas, memories, or experiences that must be carefully addressed as safely as possible. Uncovering traumas can lead to changes in mood, affect, behaviors, and ability to manage daily tasks or relationships. Additionally, attempting to change behaviors and attitudes may also create changes in mood, affect, behaviors and ability to manage daily tasks or relationships. More emergent, goal specific sessions can be scheduled as needed to attempt to stabilize and address any unmanageable thoughts, feelings, or behaviors. You should also be familiar with your local resources and crisis services in the event that higher level interventions are needed. These services may be: local doctor or therapist office visit, emergency room or crisis center assessment, 911 or other emergency interventions. By signing, I acknowledge that I understand therapy can result in changes in mood, affect, behaviors and ability to manage daily tasks or relationships. I will familiarize myself with local crisis intervention services and permit my therapist to activate these services if regular treatment sessions are deemed insufficient. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Initial Intake Overview has been reviewed by both the individual listed below as well as Philip Morrison, LCSW. The individual has been given the opportunity to ask any questions and review any areas of concern fully prior to entering into a therapeutic relationship.

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

Individual Signature / Date Philip Morrison, LCSW / Date