Just Help Out Foundation – Counseling Assistance Intake Form

Providing confidential support and funding for those in need of mental health care.

Section 1: Basic Information

Full Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Gender (optional): _____ Pronouns (optional): _____

Best way to contact you (phone, email, text, other): _____

Section 2: Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____ Aware you are seeking counseling? (Yes/No): _____

Section 3: Mental Health Background

What brings you to seek counseling support at this time?

How long have you been struggling with these issues?

Have you received mental health treatment before? (Yes/No) If yes, please describe:

Functioning Check (select all that apply):

■ Difficulty maintaining work or school responsibilities
■ Struggles in relationships
■ Persistent sadness or loss of interest
■ Difficulty sleeping or eating
■ Panic or anxiety attacks
■ Feeling detached or hopeless
■ Difficulty completing daily tasks

Section 3B: Mental Health & Medical Background

Prior Diagnoses:

Have you ever been given a mental health diagnosis? (Yes/No) _____

If yes, please list below (include approximate dates if known):

_____

_____

Current Medications:
Please list any psychiatric or other medications you are currently taking, including dosage if known:

_____

_____

Prior Suicide Attempts or Self-Harm:
Have you ever attempted suicide or engaged in self-harm? (Yes/No) _____
If yes, how many times and when was the most recent?

_____

Willingness to Engage in Treatment:
On a scale of 1–10, how motivated are you to engage in counseling and work toward improvement?
1■■ (Not at all) 2 3 4 5 6 7 8 9 ■ (Highly motivated)

What are you hoping to gain or change through counseling?

_____

_____

Section 4: Columbia Suicide Severity Rating Scale (C-SSRS) – Screening

1. Wished you were dead or could go to sleep and not wake up? (Yes/No) _____
2. Any actual thoughts of killing yourself? (Yes/No) _____
3. Been thinking about how you might kill yourself? (Yes/No) _____
4. Had these thoughts and had some intention of acting on them? (Yes/No) _____
5. Started to work out or prepared to do something to end your life? (Yes/No) _____

If yes to any, please describe:

Section 5: Insurance & Financial Information

Do you currently have health insurance? (Yes/No): _____

Insurance Company: _____ Policy Number: _____

Mental Health Copay / Deductible (if known): _____

Employment Status: _____

Approximate Monthly Income Range: ■ Under $1,000 ■ $1,000–$2,500 ■ $2,501–$4,000 ■ $4,001+

Financial barriers to paying for counseling? (Yes/No): _____

If yes, please describe:

Section 6: Consent & Privacy Notice

The Just Help Out Foundation values your privacy. All information provided will remain confidential and used only to determine eligibility for financial support and to connect you with counseling resources. If we believe you are in immediate danger, we may need to contact emergency services to keep you safe. By signing below, you give permission for the foundation to review your application and, if approved, coordinate funding directly with your selected counseling provider.

Signature: _____ Date: _____

Submit via email: nichole@justhelpoutfoundation.org
Just Help Out Foundation | www.justhelpoutfoundation.org | info@justhelpoutfoundation.org
This form is not a crisis response tool. If you are in immediate danger, call or text 988 or contact local emergency services.