Emotional Wellness, LLC

INFORMATION FORM --(*ENTIRE FORM MUST BE COMPLETED)*

Client Name_____ Referred by_____

DOB _____ Age_____ Email Address _____
(For appointment reminders only, we do not share this information)
Street_____City_____State____ Zip_____

Phone (cell)_____(hm)_____(wk)_____

Health Ins. Name _____ ID#_____ Group # _____

Name of Insured _____DOB _____Employer _____

Did client/insured contact Insurance Co. to ask if Emotional Wellness and/or your counselor are in network?
__**Yes** __**No** Did client/insured request an Authorization number: **Authorization #:**_____

IF MINOR, 18 or under:
School Name_____ Grade _____ IEP/ES/LS___ Regular Ed ____

Mother_____ DOB_____ Phone _____

Street_____City_____ State_____ Zip_____
(Check if same as client ___)
Father_____ DOB_____ Phone _____

Street_____City_____State____ Zip_____
(Check if same as client ___)

Describe the nature of the concerns:

_____

_____

Drug/Alcohol use? ___Yes ___ No, Please describe:_____

_____

Medication(s)?___Yes ___No, Name(s) and Dosage(s)_____

_____

Prescribing Doctor _____Phone # _____

Family Doctor _____Phone #_____
Previous treatment? ___Yes ___ No, Date(s)_____
Name of person and/or facility(s): _____
Other Agency involvement: ___ SAM ___ BCCYS ___ JPO ___YAP _____Other

Please check which of the following we may leave a detailed message, voice mail or information with:
__Cell Phone __Home Phone __Spouse or Significant Other __Email __Other _____

_____ _____
Client or (if Minor) Parent/Guardian Signature **Date**

EMOTIONAL WELLNESS LLC

APPOINTMENT REMINDERS & HEALTH CARE INFORMATION AUTHORIZATION

Your counselor and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder of the other information and may no longer be protected by the federal privacy rules.

You may have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received a copy of this authorization.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Please check which of the following we may leave information with:

___Cell phone ___Home phone ___Email ___Other_____

___Spouse_____(name) ___Significant other_____(name)

_____ _____
Print Name (Client) Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Name Printed Personal Representative Signature

_____
Description of personal representative's authority to act for the patient

EMOTIONAL WELLNESS LLC

CONSENT FOR USE OR DICLOSURE OF HEALTH INFORMATION
OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have respected the privacy of your health information, and always will.

There are several circumstances in which we may have to use or disclose your health care information.

1 – We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health situation.
2 – We may have to disclose your health information and billing record to another party if they are potentially responsible for the payment of your services.
3- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Please check which of the following we may leave information with:

___Cell phone ___Home phone ___Email ___Other_____

___Spouse_____(name) ___Significant other_____(name)

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. Before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

_____
Print Name

_____ _____
Signature Date

_____ _____
Authorized Provider Representative Date

EMOTIONAL WELLNESS LLC
3933 Perkiomen Ave, Suite 102
Reading, PA 19606-2718
610-779-7272

Dear Patient,

Thank you for choosing us as your behavioral health provider. The following is our financial policy. Our main concern is that you receive optimal care resulting in better health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask.

We ask that you kindly read and sign our financial policy as well as complete our patient information form prior to seeing your counselor.

Payment of services is due at the time services are rendered. We accept cash, checks and for your convenience **VISA AND MASTERCARD**. We will be happy to help process your insurance claims. **We accept assignment from most insurance companies; however you must understand that:**

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, whether your insurance company pays or not. Not all services are covered benefits in all contracts. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.
3. If the insurance company does not pay your balance **in full** within **45** days, we kindly ask that you contact your insurance carrier to help speed things along.
4. If the insurance company does not pay at all within **45** days, we require you to pay the balance due.
5. Returned checks and balances older than **60** days may be subject to an additional collection fee and/or interest charges of 1 ½% per month.

If you are in our office dues to a personal injury covered by your auto or workers compensation policy, we will make every attempt to process your claim quickly, and some of the above statement may not apply due to certain state laws. In special circumstances we will require a letter of protection from your attorney for payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

We appreciate your confidence in us and the opportunity to serve you.

Thank you,

Emotional Wellness, LLC

_____ _____

Print Name Date

_____

Signature

EMOTIONAL WELLNESS LLC

Client Information and Responsibilities

Confidentiality: Information obtained in the course of treatment is confidential to the extent of the law. Confidentiality requirements and its exceptions are fully explained on the Consent to Treatment form. Treatment is discussed within the clinic by the professional staff for supervision purposes, treatment planning and continuity of care issues. Your signature below indicates you understanding of this and permission of case discussion with supervisors.

Clients are required to maintain confidentiality regarding any information about other clients in the building. Disclosure of confidential information, including sharing the names of other clients. may be damaging and can lead to an unsuccessful discharge.

Emergencies: Emotional Wellness LLC' hours are by appointment. If it is necessary to contact the therapist at a time other than the scheduled session, you may leave a message at the practice phone number (610-779-7272) 24 hours a day. **IF YOU HAVE AN EMERGENCY, PLEASE: CALL OR VISIT THE EMERGENCY ROOM OF YOUR LOCAL HOSPITAL; CALL 911; OR CONTACT A SAM (Service Access and Management) CRISIS WORKER AT 610-236-0530. DO NOT WAIT FOR THE THERAPIST TO RETURN YOUR CALL!**

Telephone Calls: Occasionally the need to talk to the therapist may arise between normal scheduled sessions. The client will be charged for any telephone consultation time (exceeding 10 minutes) between scheduled sessions with the therapist.

Fees and Payments: The fee that you need to pay for therapy is your copay/co-insurance amount or full fee. This fee is due at every session. Fees for all services are posted. Though your insurance carrier may pay all or part of any of the charges for treatment, you are responsible for payment at the time of each session and for any charges that your insurance company denies due to lack of coverage. Outstanding balances will be sent to collections after 30 days, therefore adding a $40.00 collection fee to the total balance due.

Personal checks are accepted. A $30.00 service charge will be levied on all checks returned by a bank for insufficient funds. If more than one check is returned, service will be provided on a cash basis only. Failure to pay for treatment is sufficient reason for discharge.

Fees For Cancelled and Missed Sessions: As a result of medical necessity, attendance at sessions is closely monitored by your therapist. When an appointment is scheduled, that time is set aside for you. Therefore, if your appointment is missed or cancelled without 24 hour notice, you will be charged for the missed session. Your fee for a non-attended session that is **NOT** cancelled at least 24 hours in advance is $120.00. Fees for non-attended sessions must be paid by the next session. In an emergency, your therapist **MAY** adjust the fee. Please note the most insurance carriers do not cover fees for missed appointments. Unattended sessions may be reason for medical discharge from therapy.

Insurance: If you are currently covered by an insurance plan, your treatment may be included in your health insurance benefit. Please contact your insurance carrier or benefit manager to determine your policy's coverage for treatment. Some insurance companies cover only medically necessary or crisis oriented treatment, resulting in the authorization of sessions in small segments. Your insurance, its coverage limitations and authorization guidelines should be discussed with your therapist at the beginning of treatment. However, because your therapist cannot know all aspects of your insurance plan, please contact your insurance company directly to clarify any issues of concern. In some cases, you may want more therapy than your insurance coverage authorizes or you may choose to see a therapist outside of your insurance. If this is your choice, it will be documented as out of network treatment.

Insurance Changes: IF YOUR INSURANCE INFORMATION CHANGES AT ANY TIME, PLEASE NOTIFY US IMMEDIATELY. It is extremely important to give prior notice of **ANY** changes in your insurance coverage to your therapist. This includes if your insurance becomes inactive, changes to another carrier and/or you are covered by a new or secondary insurance during the course of treatment. A change in insurance may affect the length/form of treatment and/or the therapist that is approved to see you under that particular insurance company's guidelines. All of these issues may impact treatment in a significant way, thus we ask you to be an informed consumer of the insurance product you carry. If you fail to inform the therapist of any of the above changes, including providing us with a copy of your current insurance card, you will be responsible for full payment of services received.

Disability: Disability claim documents will not be completed by the therapist until the client has been under their care for a minimum of six months.

Discharge for Absences: Discharge will be considered for clients who miss more than two sessions during the course of treatment. Missing more than two sessions may lead to an unsuccessful discharge. As with any unsuccessful discharge, an evaluation will be required to restart treatment. Discharge is at the discretion of the therapist.

Drug and Alcohol Use: Clients must remain abstinent from all mood-altering chemicals during the entire duration of treatment, or must report relapses to the therapist. Repeated relapses could change the level of care of services. Clients may be discharged for unreported relapses. Attendance at no less than one AA or NA meeting per week is a recommendation of treatment.

I have read, understand and agree to all of the above expectations for my treatment. My signature below verifies that I have received a copy of this "Client Information and Responsibilities" form.

_____ _____

Signature of Client and/or Responsible Party Date

EMOTIONAL WELLNESS LLC

CONSENT TO TREATMENT

Client Name: _____

DOB: _____

I hereby seek and consent to take part in emotional/behavioral health treatment at Emotional Wellness LLC. I understand that my therapist and I will collaborate to develop a treatment plan that will be reviewed on a regular basis. I agree to pay for this treatment, and I understand the billing process and the fee schedule. I understand that failure to pay for costs for which I am liable may ultimately result in my account being forwarded to the proper authority for collection.

I acknowledge that I have been informed of my rights and responsibilities as a client and have had all my questions answered fully. I understand that I must call to cancel an appointment at least 24 hours in advance or I will be charged with a $120.00 no-show fee. I am aware that my insurance company and/or other third party payer may be given information about my dates of service, diagnosis, and name of the provider of services I received. I also understand that some third party payers, including managed care organizations, may request additional information in order to process my claim and authorize continuing services. Information requested may include, but not be limited to, presenting complaint, current symptoms, progress in treatment, and a copy of my treatment plan.

I understand that I have the right to terminate treatment at any time

My signature acknowledges that I have read and understand the Consent To Treatment form and agree with same.

_____

Client Signature Date

_____

Parent/Guardian (if client under age 14) Date

_____

Witness Signature Date

EMOTIONAL WELLNESS, LLC

Client Rights

1. You have the right to competent, timely treatment delivered in a respectful manner by a mental health professional.

2. You have the right to have your communications with Emotional Wellness, LLC treated in a confidential manner. You have the right to determine to whom and under what circumstances information about your treatment may be released. Confidential information may not be released without your written consent with the exceptions of suspected child abuse, emergencies, probability of imminent danger to self or others, and court orders.

3. You have the right to expect reasonable continuity of care.

4. You have the right to ask for outside consultation, evaluation, and/or treatment.

5. You have the right to have questions answered about procedures at any time.

6. You have the right to participate in the formulation of your treatment plan, which will determine the course of treatment you will receive at Emotional Wellness, LLC.

7. You have the right to refuse or withdraw from treatment.

8. You have the right to non-discriminatory treatment without prejudice to sex, race, religion, creed, color, national origin or handicap.

_____

Client Signature Date

_____

Parent/Guardian (if client under age 14) Date

_____

Witness Signature Date

Instructions for **1500 Health Insurance Claim Form** on next page,

Please **ONLY** sign and date in **box 12** and sign in **box 13.**

All other information on that form to be completed by clinician.

EALTH INSURANCE CLAIM FORM

PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
☐	☐	☐	☐	☐	☐	☐

. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
ITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
IP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. OTHER CLAIM ID (Designated by NUCC)
. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
☐ ☐					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

Instructions for **Authorization for Release of Information** on next page,

Please fill out page 10 completely for Emotional Wellness to be able to communicate with your primary care physician.
Please be sure to sign and date where it says Client Signature on both top and bottom portions.
(Top portion of form gives us permission to release to provider; bottom portion gives us permission to obtain from provider)

Please **ONLY** fill out page 11 completely if you have another party that you may wish to have involved in your care.

EMOTIONAL WELLNESS LLC (emwell.org)
3933 Perkiomen Avenue, Suite 102 * Reading, PA 19606
2481 Lancaster Pike, Shillington, PA 19607
(PH) 610-779-7272 * (FAX) 610-985-9100

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby consent and authorize Emotional Wellness LLC to disclose to _____ the following information from my record(s):

___ Initial Assessment ___ Admission/Attendance ___Progress in Treatment
___ Medical History ___ Prognosis/Diagnosis ___ Discharge Summary
___ Treatment Plan ___ Other _____

The purpose of this disclosure is to:
___ Coordinate treatment with __ family, __ other involved agencies, __ referral source
___ Secure/provide ongoing treatment ___ Other _____

_____ _____
Client Signature Date Parent/Guardian Signature Date

_____
Witness Signature Date

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol Treatment records). I understand that I have the right to request to inspect materials that shall be released. I understand that I may revoke this authorization at any time by notifying Emotional Wellness LLC in writing. This authorization shall expire six (6) months after discharge from treatment unless otherwise specified _____. Federal regulation prohibits receiver from making further disclosure without specific written consent. I understand I am entitled to a copy of this document in its completed form. ___ Accepted or ___ Refused Copy of Release of Information.

I, _____, do hereby consent and authorize Emotional Wellness LLC to receive from _____ the following information from my record(s):

___ Initial Assessment ___ Admission/Attendance ___Progress in Treatment
___ Medical History ___ Prognosis/Diagnosis ___ Discharge Summary
___ Psychiatric Evaluation ___ Social History
___ Treatment Plan ___ Other _____

The purpose of this disclosure is to:
___ Coordinate treatment with __ family, __ other involved agencies, __ referral source
___ Secure/provide ongoing treatment ___ Other _____

_____ _____
Client Signature Date **Client Date of Birth**

_____ _____
Witness Signature Date Parent/Guardian Signature Date

EMOTIONAL WELLNESS LLC (emwell.org)
3933 Perkiomen Avenue, Suite 102 * Reading, PA 19606
2481 Lancaster Pike, Shillington, PA 19607
(PH) 610-779-7272 * (FAX) 610-985-9100

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby consent and authorize Emotional Wellness LLC to disclose to _____ the following information from my record(s):

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Witness Signature Date

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___ Medical History ___ Prognosis/Diagnosis ___ Discharge Summary
___ Psychiatric Evaluation ___ Social History
___ Treatment Plan ___ Other _____

The purpose of this disclosure is to:
___ Coordinate treatment with __ family, __ other involved agencies, __ referral source
___ Secure/provide ongoing treatment ___ Other _____

_____ _____
Client Signature Date **Client Date of Birth**

_____ _____
Witness Signature Date Parent/Guardian Signature Date

NAME:_____ DOB:_____

Emotional Wellness Intake Assessment Form

Briefly describe why you are coming in for counseling:

_____

_____

_____

Please list what you would like to gain from counseling:

*1.*_____

*2.*_____

*3.*_____

How do you feel about being in counseling?

_____

_____

Health/ Medical Information

Please answer the following questions using 5 through 1: (5-Excellent, 4-Good, 3-Average, 2-Poor, 1-Failing)

How would you currently rate your physical health: _____
How would you currently rate your mental health: _____
How would you currently rate your spiritual health: _____ (if does not apply to you, please use N/A)

Do you now have, or have you had in the past, any of the following? Check all that apply:

	Now	Past		Now	Past		Now	Past
Asthma			Allergies			Headaches		
Brain Injury			Epilepsy			Heart Disease		
Seizures			Breathing Problems			High Blood Pressure		
Digestive Disorders			Immune System Problems			Hearing Problems		
Cancer			Diabetes			Arthritis		
Urinary Disorders			Tuberculosis			Thyroid Disorder		
Multiple Sclerosis			Chronic Fatigue Syndrome			Fibromyalgia		
Pregnancy (how many)			Miscarriage (how many)			Abortion (how many)		
Surgery			Problems with menstruation (women and girls only)			Other/ Comments:		

Are you experiencing bodily aches and pains? ☐ Yes ☐ No
If yes, please describe:

_____

_____

NAME:_____ DOB:_____

Are you currently under the care of a Doctor or other medical health professional? ☐ Yes ☐ No
Name of Primary Care Physician: _____
Physician
Phone#:_____Address:_____
Name of Specialist Physician: _____ Physician
Phone#:_____
Address:_____

Please list any prescription medications you are currently taking:

_____
_____
_____
_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____
_____

Do you currently exercise? ☐ Yes ☐ No
If yes, please indicate how many times per week: _____

Developmental History

Did your mother have prenatal care? ☐ Yes ☐ No ☐ Unknown
Your mother's pregnancy with you was: ☐ Uneventful ☐ Abnormal Events
Please describe if abnormal events:

_____
_____
_____
_____

Your birth was: ☐ Normal Birth ☐ Abnormal Events ☐ Unknown
Please describe if abnormal events:

_____
_____
_____
_____

Milestones:	Early	On time	Late
Sat without support			
Walked			
Toilet trained			
Talked			

☐ Unknown

List any problems/ concerns with the following, if none, mark "normal/ unremarkable:"
Infancy/ Childhood: ☐ Normal/ unremarkable ☐ Problems/ concerns, describe:

_____

_____

☐ Unknown

Adolescence: ☐ Normal/ unremarkable ☐ Problems/ concerns, describe:

_____

_____

☐ Unknown

Substance Use

Please indicate substance use. How many times per day/week, age of first use, past use history, and length of time used.

☐ **Not Applicable (N/A)**

Substance	Current (within 6 months)	Prior history (beyond 6 months)	Amount	Frequency	Age	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Meth-amphetamines						
PCP/LSD/ Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have you ever believed your substance use was a problem for you? ☐ Yes ☐ No
Comments:_____

Has anyone ever told you they believed your substance use was a problem? ☐ Yes ☐ No
Comments:_____
Have you ever had withdrawal symptoms when trying to stop using any substances *(irritability, anxiety, trembling, nausea, sweating, etc....)*? ☐ Yes ☐ No
Comments:_____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
☐ Yes ☐ No If yes, please describe:_____

Have you ever participated in drug and alcohol treatment? ☐ Yes ☐ No
If yes, please list **type**, **length**, **dates**, and **age at time you received these services**:

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous? ☐ Yes ☐ No
If yes, please list length of time sober and number of meetings you attend per week:

Mental Health Information

Have you ever been in counseling/therapy before? ☐ Yes ☐ No
If yes, what did you find useful/ effective? Not effective?

Are you currently receiving mental health services? ☐ Yes ☐ No
If yes, please list name of practitioner and type of services you are receiving:

Have you ever been hospitalized for mental health concerns? ☐ Yes ☐ No
If yes, list date(s) and length of stay:

Have you ever been diagnosed with a mental illness*(anxiety, depression, bi-polar disorder, eating disorder, etc...)*? ☐ Yes ☐ No
If yes, please list illness(es) and date (s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness *(anxiety, depression, bi-polar disorder, eating disorder, etc...)*? ☐ Yes ☐ No
If yes, please list relationship(s) and illness(es):

_____

_____

Have you ever or are you currently engaging in self harm? Currently: _____ Past: _____

Have you ever or are you currently contemplating suicide? Currently: _____ Past: _____

Have you ever or are you currently contemplating harming another person?
Currently: _____ Past: _____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes please list date(s), method(s), and your age at time of attempt:

_____

_____

Has anyone in your family ever attempted suicide? ☐ Yes ☐ No
If yes please list relationship: _____
Has anyone in your family ever completed suicide? ☐ Yes ☐ No
If yes please list relationship: _____
Has anyone else in your life ever attempted _____ or completed suicide? _____
Relationship: _____
Do you currently or have you ever had trouble sleeping? ☐ Yes ☐ No
If yes, please describe:

_____

_____

Do you currently or have you ever had problems with eating or with food? ☐ Yes ☐ No
If yes, please describe:

_____

_____

_____

Spiritual Information

Have you ever or do you currently engage in a personal faith/ spiritual practice? ☐ Yes ☐ No
If yes please describe:

_____

Have you ever, or do you currently belong to a faith/ spiritual community (church, synagogue, temple, religious order, etc.)? ☐ Yes ☐ No
If yes, please describe your current level of connection and involvement:

_____

_____

_____

Do you want to incorporate your faith/spirituality into the counseling process? ☐ Yes ☐ No
If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction:

_____

_____

_____

Relationship Information

Age of first sexual experience if applicable: _____

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual
Do you have any concerns regarding sexuality? ☐ Yes ☐ No If yes, please explain:

_____

_____

Are you currently in a relationship? ☐ Yes ☐ No
If yes, please list status: _____ Name of Person: _____
Length of time you have known each other: _____
Length of time you have been together: _____
Do you currently live together? ☐ Yes ☐ No
Number of marriages: _____ Number of divorces: _____ N/A:_____
If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties you would like to address in individual counseling? ☐ Yes ☐ No
If yes, please briefly describe:

_____

_____

If widowed, your age at death of spouse: ____

Supportive friends:

_____

_____

Family Information

Please describe your home environment and neighborhood: ☐ Safe ☐ Comfortable ☐ Unsafe

Unsafe because: _____
Do you have children? ☐ Yes ☐ No
If yes, please list below: (If more space is needed, please use back of this page)

Name	Age	Lives with you/custody status if relevant.	Quality of relationship (circle one)	Comments regarding nature of the relationship.

NAME:_____ DOB:_____

Besides children ***(listed above),*** who live with you, who else lives in your current residence?

Name	Age	Relationship	Quality of relationship (circle one)
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

Were you adopted? ☐ Yes ☐ No If yes, your age at time of adoption: _____

With whom did you live until the age of 18?

_____

_____

Did your parents ever divorce? ☐ Yes ☐ No If yes, your age at time of divorce: _____

If divorced, did your parents ever re-marry? ☐ Yes ☐ No

If yes, list parent(s) and your age(s) at time of remarriage:

_____

_____

Were you ever in foster care or residential care? ☐ Yes ☐ No
If yes, please list age and living situation:

_____

_____

Mother's current age: _____ If deceased, her age at death: _____ Your age at time of death: _____

Father's current age: _____ If deceased, his age at death: _____ Your age at time of death: _____

If you have siblings ***(not listed above/ in the home)***, please list them below:

Name	Age	Relationship(brother/sister/step-sibling)	Quality of relationship (circle one)
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

NAME:_____ DOB:_____

Please describe significant family events and/or early loses in your life:

_____

_____

Have you ever experienced the death of a family member or a close friend? ☐ Yes ☐ No If yes please list relationship and your age at time of their death:

_____

_____

Please indicate if **you or a member of your immediate family** experienced any of the following. If a family member, please indicate relationship(s):

Event Self Other Relationship

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Frequent/Mult-Moves			
Physical Abuse				Discrimination			
Sexual Abuse				Lived over-seas			
Domestic Violence				Financial Problems			
Neglect				Military member			
Substance Abuse				Homelessness			
Serious Illness				Legal Problems			
Accident or Injury				Other			

Does your partner/ spouse humiliate you or call you names? ☐ Yes ☐ No

Have you ever been in a relationship in which you were humiliated or called names?
☐ Yes ☐ No

Has your partner *(circle one of the following)* been/ is violent toward you? ☐ Yes ☐ No

Educational Information

Is the patient a minor under 18? ☐ Yes ☐ No ***(If YES, please skip the next "degree" section.)***

Diploma/ Degree Information:

Number of years of education completed: _____ Degree(s) achieved (please mark all that apply):

High School Diploma		G.E.D.		Vocational/Trade School Certificate		Associates Degree	
Bachelor's Degree		Master's Degree		Doctorate Degree		Other	

MINORS UNDER 18 ONLY:

Current grade: _____ Current school: _____

Regular or special education (learning/ emotional support): _____

Performance:

Elementary: _____

Secondary: _____

Check any of the following that apply:

Academic problems		Truancy	
Disciplinary problems		Problems with peers	
Difficulty separating from parents		Bullied/ teased	
Problems with teachers		Enjoys school	
Hates school		Active in school activities/ sports	

Grades from most recent marking period: _____

Child's interests, hobbies, etc:_____

_____

_____

Volunteer work? ☐ Yes ☐ No

If yes, please list: _____

What does the child think about counseling?

_____

_____

_____

Vocational Information ☐ **N/A because patient is a child below working age**

Are you currently employed? ☐ Yes ☐ No

If yes, please list position title, name of employer, type of work, and length of time at employment:

_____

_____

If you are not currently working, how long have you been **un**-employed?_____

What types of jobs have you typically held?_____

What is the longest period of time you have ever worked at one job?_____

Are you currently considering a change in job or career: ☐ Yes ☐ No

If yes, what type of work are you interested in doing:

_____

_____

Have you ever served in the military? ☐ Yes ☐ No
If yes, please list **branch, rank, and current status (active/discharged)**:

_____

If deployed please list dates and family/relationship status pre and post deployment:

_____

_____

Legal Information

Have you ever been the victim of a crime? ☐ Yes ☐ No
If yes, please list date and briefly describe:

_____

_____

_____

Are you currently involved in divorce or child custody proceedings? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No
If yes, please explain:

_____

_____

_____

Currently on parole or probation? ☐ Yes ☐ No
If yes, who is your probation officer and contact number?

_____

Community Involvement

Is there anyone we should be in contact with for continuity of care? (We must have you sign a release for each provider). Examples of providers are: Physicians, Case Managers, Probation Officers, Caseworkers. If there are other providers involved in your care, please list them below:

NAME	RELATIONSHIP	PHONE

Please list your personal hobbies and interests:

_____

_____

_____
Signature of person completing form (Client 14 and older, parent/guardian if under 14)

NAME:_____ DOB:_____

NOTES

CLINICIAN ONLY

NAME:_____ DOB:_____

Mental Status:

APPEARANCE:
____Appropriate
____Disheveled
____Other_____

AFFECT:
____Depressed
____Sad
____Flat
____Apathetic
____Anxious
____Agitated
____Angry
____Paranoid
____Euphoric
____Cheerful
____Laughing
____Congruent to Mood
_____
_____

MOOD:
____Normal
____Depressed
____Anxious
____Irritable
____Euphoric
____Labile
____Angry

BEHAVIORAL PRESENTATION:
____Cooperative
____Uncooperative
____Withdrawn
____Evasive
____Histrionic
____Paranoid/ Suspicious
____Manipulative
____Inappropriate
____Alert

RANGE OF AFFECT:
____Normal
____Restricted

SPEECH:
____Normal/Coherent
____Pressured
____Hesitant
____Monotone
____Mute
____Speech
____Other_____

VEGETATIVE BEHAVIORS:
____Incr./Decrease Sleep
____Incr./Decrease Appetite
____Incr./Decrease Energy Level
____Frequent Crying/ Tearfulness
____Decreased Motivation
____Loss of Interest/ Pleasure

THOUGHT PROCESS:
____Clear/Coherent
____Blocked
____Confused
____Illogical
____Loose
____Tangential
____Circumstantial
____Flight of Ideas
____Pressured
____Abstraction
____Psychotic

INSIGHT:
____Good
____Fair
____Absent

THOUGHT CONTENT:
____Non-Psychotic
____Psychotic

Sensorium & Intellect:

CONCENTRATION:
____Decreased
____Easily Distracted
____Preoccupied
____Appropriate

ORIENTATION:
____Oriented
____Time
____Place
____Person
____Disoriented

MEMORY DIFFICULTIES:
____Long-Term
____Short-Term
____Immed. Retention/ Recall
____Calculations (7's)

JUDGEMENT:
____Good
____Fair
____Poor
____Absent

Additional Notes:

_____
_____
_____
_____
_____

CLINICIAN ONLY

NAME:_____ DOB:_____

SUMMARY

Integrated summary and evaluation:

_____
_____
_____
_____
_____

DIAGNOSIS

Axis I _____
_____
_____
Axis II _____
Axis III_____
Axis IV_____
Axis V GAF _____

TREATMENT PLAN

Goal:

_____
Objective: _____ Target Date: _____
Goal:

_____
Objective: _____ Target Date:_____
Goal:

_____
Objective: _____ Target Date: _____

Client agreement with treatment plan: ____ Yes ____ No

_____ _____
Client Signature Date Clinician Signature Date