

ADULT Client Intake Form

Today's Date: _____

Please **print legibly**, providing information to questions below and **bring to your first session**.
All information you provide is protected as confidential.

Emergency Contact Information:

Name: _____ Phone: _____ Relationship to Client: _____

Client Name: _____
(Last, First, Middle Initial)

Client Racial Ethnic Identity: American Indian/Alaska Native Asian/Asian Indian
 Black/African American Hispanic/Latino Middle Eastern Pacific Islander/Native Hawaiian White/Caucasian

Client Birth Date: ____/____/____ Age: _____ Gender: _____

Client SSN: _____ - _____ - _____

Address: _____
(Street, Number, City, State, & Zip Code)

Home Phone: _____ May we leave a message? Yes No

Cell/Other Phone: _____ May we leave a message? Yes No

Marital Status:
 Never Married Domestic Partnership Married Separated Divorced Widowed

Highest education level and degree: _____

Employer: _____

Home Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Cell/Other Phone: _____ May we leave a message? Yes No

Preferred Number to Contact You (Please Circle): Home Work Cell/Other

Others living in client's home:

Name	Relationship to Client	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION SHEET (if applicable)

Client Name: _____

Street Address: _____

City, State, Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Marital Status: Married _____ Single _____ Divorced _____ Gender: Male _____ Female _____

Date of Birth: _____ Social Security #: _____

Insured's Name: _____

Insured's Address: _____

City, State, Zip: _____

Client's Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Employer: _____

Primary Insurance Carrier: _____

Primary Insurance Phone #: _____

Primary Insurance ID#: _____

Member #: _____ Group #: _____

Secondary Insurance Carrier: _____

Secondary Insurance Phone #: _____

Secondary Insurance ID#: _____

Member #: _____ Group #: _____

AUTHORIZATION INFORMATION: (Please enclose a copy of authorization letter if available)

1. Number of Sessions: _____

2. Start and End Dates: _____

3. Authorization #: _____

MENTAL HEALTH HISTORY

1. Mental Health/Substance Abuse Family History to include self (please provide relationship, diagnosis and/or substance used):

2. Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services, etc.)?

Yes No

(If you selected yes, please fill out the following):

Month/Year	Provider	Outcome

3. Are you currently taking any prescription medication?

Yes No

Please list: _____

4. Have you ever been prescribed psychiatric medication? Yes No

Please list and provide dates: _____

5. Do you currently see a psychiatrist or another mental health provider? Yes No

If yes, may we contact them to coordinate your care? Yes No

If you answered yes, please list the information of your current psychiatrist or mental health provider: _____

6. May we contact your primary care provider (PCP) to coordinate your care? Yes No

If you answered yes, please list the information (name and phone number) of your current primary care physician (PCP):

GENERAL HEALTH AND MENTAL EVALUATION

1. How is your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How are your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes No

If yes, please describe: _____

8. Do you drink alcohol more than once a week? Yes No

If yes, how often do you consume alcohol? Daily Weekly Monthly

Infrequently

9. Do you engage in recreational drug use? Yes No

If yes, how often do you engage recreational drug use? Daily Weekly Monthly Infrequently

Please provide name of drugs used. _____

10. Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

11. Are you sexually active? Yes No

If yes, for how long? _____

12. Are you heterosexual, bi-sexual, or homosexual? Please circle.

On a scale of 1-10, 10 being best, how would you rate the relationship? _____

13. What significant life changes or stressful events have you experienced recently?

GENERAL HEALTH AND MENTAL EVALUATION Cont'd.

14. **FAMILY MENTAL HEALTH HISTORY:** In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse: Yes No

Anxiety: Yes No

Depression: Yes No

Domestic Violence: Yes No

Eating Disorders: Yes No

Obesity: Yes No

Obsessive Compulsive Behavior: Yes No

Schizophrenia: Yes No

Suicide Thoughts: Yes No

Suicide Attempts: Yes No

15. **INDIVIDUAL MENTAL HEALTH HISTORY:** Please check all that you may have experienced in the past. If checked, please note the month/year near the item or in the space below the item.

- Distractibility
- Change in Appetite
- Suspicion/paranoia
- Hyperactivity
- Fatigue
- Lack of Motivation
- Racing Thoughts
- Impulsivity
- Withdrawal from people
- Excessive Energy
- Boredom
- Anxiety/worry
- Rapid mood swings
- Poor memory/confusion
- Panic attacks
- Sleep problems
- Season mood changes
- Fear away from home
- Nightmares
- Sadness/depression
- Social Discomfort
- Eating Problems
- Loss of pleasure/interest
- Obsessive thoughts
- Gambling problems
- Hopelessness
- Compulsive behavior
- Computer addiction
- Thoughts of death
- Aggression/fights
- Problems with pornography
- Self-harm behaviors
- Frequent arguments
- Parenting Problems
- Crying Spells
- Irritability/anger
- Sexual Problems
- Loneliness
- Homicidal Thoughts
- Relationship problems
- Low self-worth
- Flashbacks
- Work/school problems
- Guilt/shame
- Hearing Voices
- Alcohol/drug use
- Visual hallucinations
- Recurring, disturbing memories
- Other: _____

16. Are your problems affecting any of the following?

- Handling everyday tasks
- Self-esteem
- Relationships
- Hygiene
- Work/School
- Housing
- Legal matters
- Finances
- Recreational activities
- Sexual activity
- Health

17. Have you ever had thoughts of, made statements regarding, or attempted to hurt yourself? Yes No

If yes, please describe: _____

18. Have you ever had thoughts of, made statements regarding, or attempted to hurt someone else? Yes No

If yes, please describe: _____

19. Have you recently been physically hurt or threatened by someone else? Yes No

If yes, please describe: _____

20. Have you gambled in the past 6 months? Yes No

If yes, let us know the following:

21. Have you ever felt the need to bet more and more money? Yes No

Have you ever had to lie to people important to you about how much you gambled? Yes No

GENERAL HEALTH AND MENTAL EVALUATION Cont'd.

22. Have you ever been concerned about your use of drugs/alcohol? Yes No

23. Has anyone ever expressed concern about your use of drugs/alcohol? Yes No

If yes, who? _____

24. Have you ever experienced any of the following?

- Allergies Asthma Headaches Stomach aches Chronic Pain Surgery Serious accident
 Head injury Dizziness/fainting Meningitis Seizures Vision Problems High fevers Diabetes
 Hearing problems Miscarriage STD/STI Abortion Sleep disorder Other: _____

25. Please list any CURRENT health concerns:

26. Please list current over-the counter medications and prescription drugs along with date of initial use:

27. Does anyone in the home smoke? Yes No

If so, who does and how much? _____

28. Check which of the following you use, and note the amount and frequency of each:

- Caffeine: _____
 Coffee: _____
 Sodas: _____
 Other Drinks Pills: _____
 Alcohol: _____
 Cocaine, Crack: _____
 Tobacco: _____
 Marijuana: _____
 LSD: _____
 _____ Inhalants: ____
 Other: _____

INTERESTS, ACCOMPLISHMENTS, AND ADDITIONAL CONCERNS

1. What are your main hobbies, interest, and talents?

2. What are your greatest areas of accomplishment?

3. What do you consider to be some of your weaknesses?

4. What do you dislike doing most?

5. Have you ever been affiliated with the military? Yes No

If yes, please answer the following: Branch _____ Date/Type of Discharge _____ Rank _____

6. Have you ever been convicted of a misdemeanor or felony? Yes No

If yes, please explain: _____

7. Are you currently on probation? Yes No

If yes, please explain why and how long:

8. Are you currently involved in any divorce or child custody proceedings? Yes No

If yes, please explain:

9. Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief:

10. Why are you here in therapy (counseling)? _____

11. How much were you pressured to come to therapy (counseling) today? (please circle)

Not at all pressured A little pressured Somewhat pressured Quite Pressured Very pressured

INTERESTS, ACCOMPLISHMENTS, AND ADDITIONAL CONCERNS Cont'd.

12. What is the goal to be accomplished out of your time here in therapy (counseling)?

How did you hear about Art of Therapy Counseling & Consulting Group, LLC? _____

Would you like to join our email list for upcoming workshops and groups? Yes No

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

We respect your email privacy. You will not receive unsolicited marketing. We will not share, transfer, sell or rent your information.

Note: All information requested in this form will be kept confidential

AUTHORIZATION FOR TWO-WAY RELEASE OF INFORMATION

I (we), the undersigned authorize:

Name of provider/agency holding information

Address of provider/agency holding information

-to release information relevant to the assessment and treatment of the undersigned to Art of Therapy Counseling & Consulting Group (AOT), LLC. I (we) also authorize AOT to release relevant information to the person and/or agency listed above.

Printed name of client

Date of Birth

Printed name of client

Date of Birth

I (we) understand all information to be obtained from the provider/agency above is to be kept confidential and cannot be released by the recipient without our written consent. This authorization will expire one year from the date of signature or upon termination of services with AOT, whichever first. I (we) understand we have the right to withdraw this authorization for release of information at any time.

Printed Name

Relationship to Client

Signature and Date

Printed Name

Relationship to Client

Signature and Date

Printed Name/Signature of Witness

Date

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS

Client name: _____

Welcome to Art of Therapy Counseling and Consulting Group, LLC. Congratulations on taking the first and an extremely important step towards achieving your goals. Below you will find information on counseling as well as your rights as a client. Here at Art of Therapy Counseling & Consulting Group (may hereinafter be referred to as AOT), your treatment will be based on the standard practices, training, and experiences of marriage and family therapists, psychotherapists, professional counselors, social workers, psychologists, and life coaches.

How Counseling & Therapy Works:

The process of counseling (also known as therapy) will begin with an intake process designed to evaluate your needs and goals so that we can together come up with a treatment plan. This usually takes one session, but could take several, depending on the circumstances. If you or your therapist believes someone else could better meet your needs, you have the option of referrals to other professionals being provided to you. Your therapy sessions will end once your goals have been accomplished or you decide you do not need therapy anymore and terminate sessions.

Ending Therapy Sessions:

As stated above, you have the right to end therapy at any time. It is recommended that you have at least one more face-to face session to end therapy services verses terminating over the phone, mail, e-mail, or not showing up to a scheduled session. Upon discharge, you may be provided with a Client Satisfaction form to provide the therapist with feedback on the therapy process and your experience. We are always looking to improve services; therefore, your feedback is important to us.

Your Rights as a Client:

As a client, you have all of the rights established by the state of Florida governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, of requesting a different therapist, of ending treatment at any time, of accessing the client grievance procedures, and of having the records of your treatment kept in confidence. At any point you feel you have been harmed or mistreated, and efforts to discuss this with therapist are unsatisfactory, you may contact the Florida Department of Behavioral Health and Developmental Disabilities for appropriate grievance procedures. By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

Emergency Contact:

Your therapist will provide you with a voicemail/contact phone number and will let you know his/her availability in an emergency. In the event of a mental health emergency in which you are not able to contact your therapist, you should call 911 immediately or go to the nearest hospital emergency room. By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

Court Subpoena's and Personal Legal Matters:

I understand that in order for my therapist's work to remain effective, it is in my and/or my child's best interests to not involve my therapist in legal proceedings outside of those covered in the confidentiality statement. The rate for legal depositions, requested by either myself or my attorney, is \$2000.00 total for a maximum of 4 hours. Cancellation fee is \$2500.00 if less than 48-hour notice. **Clients are discouraged from having their therapist subpoenaed. Even though the client is responsible for fees, this does not mean the therapists' testimony will be solely in the client's favor.** My therapist at AOT will only testify to the facts of the case and to her professional opinion. I understand the rate for a requested court appearance, with or without my therapist's testimony is \$500.00 per hour. A retainer of \$5000.00 is due in advance. If a subpoena or notice for my therapist to meet an attorney(s) is received without a minimum of 48 business hour notice there will be an additional \$500.00 "express" charge. If the case is reset with less than 72 business hours' notice, then I will be charged \$500 (in addition to the retainer of \$5000.00). There is also a fee for travel

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

reimbursement. I understand all requested deposition and court appearance fees must be paid in full 30 days prior to the scheduled deposition or trial, unless other arrangements have been made in writing. The party requesting the deposition or court appearance is responsible for full payment. I understand that these fees are not covered by insurance, and I will be fully financially responsible. By initialing below, I am acknowledging understanding of all the policies in this paragraph.

Responsible party's initials on line above

Other Legal Related Fees:

1. Preparation time (including time for submission of records): \$450.00/hour
 2. Phone calls: \$450.00/hour
 3. Depositions: \$2000.00 total (maximum 4 hours)
 4. Time required in giving testimony: \$500.00/hour (2 hour minimum)
 5. Mileage: \$0.55/mile
 6. Travel time away from office due to depositions, testimony, or other legal and/or court actions: \$450.00/hour (1 hour minimum)
 7. All attorney fees and costs (including travel) incurred by the therapist as a result of the legal action.
 8. Filing a document with the court: \$450.00
 9. The minimum charge for a court appearance: \$1450.00 per day
- By initialing below, I am acknowledging understanding of the fees above.

Responsible party's initials on line above

Payment, Fees, and Expectations:

I hereby consent to my provider at Art of Therapy Counseling & Consulting Group, LLC to treat me for counseling and psychotherapy services. In addition to appointments, I may be charged for other professional services to include telephone conversations longer than 10 minutes, requests for filling out additional forms, writing reports/summaries, and any other services that I may require. I understand that I am financially responsible for all charges regardless of insurance. I may seek insurance reimbursement on my own, but am aware my insurance provider may not cover services at AOT. Some services that I require may not be covered under existing insurance policies and I agree to assume full financial responsibility for those services. If I become involved in litigation, in which AOT's participation is required, I will be expected to pay administrative fees for the professional time required. Due to the complexity and difficulty of legal involvement, fees for preparation and attendance at any legal proceeding in the local area are covered above. Each counseling/psychotherapy session is generally 45 minutes in length and may be scheduled at varying time intervals including weekly, bi-weekly, or monthly. AOT's standard fee is \$200.00 per session but this fee may be adjusted based on my family size or income. If my insurance company is billed, I understand the standard fee of \$200.00 for initial session and \$200.00 for consecutive sessions will be billed and I am responsible for the co-pay. The agreed upon initial assessment fee is _____ with additional session fees in the amount of _____ with a co-pay of _____. Planned sessions lasting longer than 60 minutes will be charged in 15 minute increments. I also understand if I wish to pay with cash I must bring exact cash for payment of services as AOT may not always have change.

Records Requests from Client

1. A charge of \$25.00 will be collected for administrative costs.
2. Postage charge, plus tax may also be charged.
3. The following fees will apply for copying documents:
 - a. \$1.00 per page for the first 25 pages
 - b. \$0.25 per each additional page
4. For records that are not in paper form, therapist shall be entitled to recover the full reasonable cost of reproduction.
5. \$450.00 per document for letters and treatment summaries.

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

Records Requests from Someone Other Than Client:

1. A charge of \$25.00 will be collected for administrative costs.
2. Postage charge, plus tax may also be charged.
3. The following fees will apply for copying documents:
 - a. \$1.00 per page
 - b. \$2.00 per page for non-paper documents printed
 - c. A fee of \$5.00 for each year of records requested
4. \$450.00 per document for letters and treatment summaries.

By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

Cancellations, No-shows, and Late Arrivals:

AOT has the right to reschedule my session if I am more than 10 minutes late, however, no fee will be charged for the missed session. If I cannot make my appointment, I agree to notify AOT at least 24 hours in advance, or as soon as possible, **prior** to the scheduled appointment time in order to avoid late charges. If I forget an appointment, I am still financially obligated to pay the full cost of the appointment to cover for staff and administrative costs. AOT requires all new clients to either leave a signed, undated check on file for the amount of a session for such eventualities, or to authorize a charge on their credit card for missed and late cancelled appointments. All fee balances must be paid prior to the next scheduled appointment. I understand that my insurance plan will not cover these charges. I understand that if I have three late cancellations and/or 2 no shows, therapy may be terminated. By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

Returned Checks:

AOT will assess a returned check fee of \$35.00 in addition to the amount of the returned check. In cases of repeated returns of checks by a client, AOT reserves the right to no longer accept checks by me. If I stop attending sessions and owe a balance, AOT will seek to recoup fees by first contacting me. If I avoid AOT, am unable to be reached by AOT, or refuse to pay, AOT reserves the right to provide my name, contact information, and amount owed to a collection agency. I acknowledge that by not paying for services already received, I am waiving my right to confidentiality for the purposes of collections only. By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

Confidentiality:

I understand that information obtained during the course of treatment will not be released without consent, except in the case of emergency or as required by law. I understand that confidentiality is waived if a client becomes a danger to self or others, if session records are subpoenaed by court of law, in the case of physical or sexual abuse of minors, the elderly, disabled, or incompetent others, and in an effort for AOT to collect debts. I also give authorization for AOT to release any and all information regarding diagnosis, treatment, and prognosis with respect to any mental condition and / or treatment to my insurance company (s) or its legal representative as indicated and considered to be necessary for obligations of the insurance company to be fulfilled and for determination of eligibility benefits under my existing policy. By initialing below, I am acknowledging understanding of the policies in this paragraph.

Responsible party's initials on line above

INFORMED CONSENT TO THERAPY AND CLIENT NOTICE OF RIGHTS CONT'D.

I acknowledge that I am voluntarily consenting to treatment and that this consent may be revoked at any time. By signing this form, I understand and I agree with the terms and conditions of this form. Please initial below.

- I have seen and read the information contained in this Welcome Note & Notice of Rights.
- I have seen and/or been offered a copy of Art of Therapy Counseling & Consulting Group confidentiality policy practices as mandated by the *Health Information Portability & Accountability Act* (HIPAA).
- I consent to Art of Therapy Counseling & Consulting Group to provide treatment as described in this form.
- I consent to allowing my therapist to consult with other providers for myself and/or my family.
- I will pay for my therapy expenses as described above.
- I hereby authorize payment directly to Art of Therapy Counseling & Consulting Group of any benefits due me for counseling/psychotherapy. I understand that I am responsible for any amount not covered by my insurance.

Please *initial* if using insurance or EAPs: _____ I hereby authorize the release of healthcare information necessary to process any claims generated by Art of Therapy Counseling & Consulting Group.

I acknowledge that I have received a copy of Art of Therapy Counseling & Consulting Group, LLC (AOT) informed consent to confidentiality/Notice of Privacy Practice for Protected Health Information. I understand that AOT has the right to change/update its' Notice of Privacy Practice for Protected Health Information.

_____	_____
Client's Name (Print)	Date
_____	_____
Client's Signature	Date
_____	_____
Client's Name (Print)	Date
_____	_____
Client's Signature	Date
_____	_____
Witness Name (Print)	Date
_____	_____
Witness Signature	Date