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

2325 Q Street Referral: Legal\_\_\_\_\_\_ Probation\_\_\_\_\_\_\_

Bedford IN 47421 County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(P) 812-279-HOPE (4673) Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(F) 812-279-4672

**ADULT INTAKE PAPERWORK**

**First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(No post office boxes allowed. If you require statement be mailed to a PO Box please inform staff)

Email (If you will allow contact via email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number we can text or leave message:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name/relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Insured if other than self:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_ **Insureds Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***!!APPOINTMENT REMINDERS!!*** I want TEXT reminder: YES\_\_\_ NO \_\_\_ ***OR*** I want phone call reminder YES\_\_\_ NO \_\_\_

**INSURANCE / PAYMENTS**

We file claims with your insurance company as a **COURTESY**. **All deductibles and copays are due before services are rendered.** Concerning a minor child, payment is due at the time of service, regardless of which parent is responsible. We make no guarantee as to your insurance benefits/copays. We forward information we receive in attempts to preauthorize. You are responsible for any remainder balances that insurance does not cover. If insufficient funds are collected at the time of service, you will be expected to pay within 30 days. All payments not made within 30 days of dated invoice will incur a 5% monthly billing fee and will be subject to collections.

Self-pay rates are optional when insurance is not available. **EVALUATION:** $120.00; **FAMILY:** $83.00; **FAMILY w/o PATIENT:** $70.00; **INDIVIDUAL:** $70.00. Rates are subject to change.

**SCC only accepts Medicaid as a PRIMARY INSURANCE**. If Medicaid becomes a secondary insurance and you choose to receive or continue receiving treatment at SCC, even though there are providers in the area that would accept Medicaid as a secondary, you will be responsible for the amount not covered by your primary insurance.

**Payment for Services:** I understand that all professional services rendered are to be charged to me. All charges are due at the time of service unless other arrangements have been made in advance. If any balance is not paid, when due, the balance plus interest will accrue at the rate of 5% per month, 18% annual will be charged. I agree to pay all collection costs including collection agency fees, reasonable attorney fee and court costs related to the recovery of money due for services by SCC. **I understand that it is my responsibility to inform SCC of any changes in insurance and to supply any documentation or information necessary to process claims.**

**NO CALL / NOSHOW AND LATE CANCELLATION POLICY**

A **$35.00 fee** will apply for any appointment cancelled less than 24 hours prior to appointment time or for any appointment you fail to attend. The fee will be due prior to the next scheduled appointment. Further, if arriving past your scheduled appointment time, you will need to re-schedule that appointment and a $35.00 late fee may be applied. Insurances typically do not cover said fees. If you no show / no call for (2) consecutive appointments or regularly cancel and reschedule, it is at the clinician’s discretion to reschedule in the future or refer you to another facility. If you have rotating weekly appointments, missing two in a row, could mean losing your assigned time.

**Directions for filing out the Intake Paperwork:**

Read all information. Ask for clarification as needed. Sign and date the bottom of each page. This will signify that you have read and understand and are aware of the information presented. Answer all questions as thoroughly as possible.

Printed Name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stone City Counseling, Inc’s Rules Notifications**—applicable to all clients

Stone City Counseling, Inc (SCC) is committed to the goals of promoting the welfare and dignity of all people who are consumers of our services. We will strive to deliver services in a respectful, responsive, and efficient manner. It is our goal to assist people who are experiencing difficulties in and around addictions and mental illness, better manage their illness by achieving their goals and be able to function in their daily lives at work and in the community. If any questions, comments or concerns, pleas speak with the office manager for clarification.

Our regular office hours, with an attending office manager, are Monday through Thursday 9:00 a.m. to 4:00 p.m. An answering machine is available to leave detailed messages 24/7. In the event of an emergency, or threat of self-harm, go directly to the local emergency room or call 911.

Each client is greeted by and referred by their first name. Each client is greeted individually at the front window. Client seen in public areas outside of Stone City Counseling, Inc (by staff), will not be approached/acknowledge by staff . Staff adheres to strict standards of confidentiality and requires all conversations related to clinical information or demographic information to be held only in the secure/sound proof offices/areas.

**Confidentiality/records:** The clinic offers a secured office. When calls come in there is a glass window that divides office from lobby. Each clinician has sound proof doors with seals at the bottom. The paperwork that is completed by the client is scanned into the client’s digital file. The original paperwork is then shredded. Online records are maintained and secured by the security and features of [www.therapyappointment.com](http://www.therapyappointment.com) . The fax line is secured in the business office as well and is not subject to view from the lobby. Additional all clinicians are instructed to have proper placement of computer screens or use of screen savers that maintain confidentiality. Each electronic charting/scheduling feature requires dual passwords and times out in the event of disruption.

**Legal Issues requiring Clinician participation**

**If at any point your case becomes a legal issue requiring court attendance** in/on your behalf and/or conferences OUTSIDE of office setting: all travel, any preparations (Phone calls, reports, written recommendations, etc,) any clinical involvement is charged at a rate of $300 per hour billed in 10 minute increments and invoiced with payment due upon receipt. **PLEASE BE ADVISED, SCC DOES NOT WISH TO PARTICIPATE IN CUSTODY SUITS AND/OR MAKING CLINICAL RECOMMENDATIONS.**

A **$400.00** retainer for inside Lawrence County and a **$500.00** retainer for outside Lawrence County is required. This retainer **DOES NOT** cover the hourly fee. It is payable to the clinician **two weeks prior** to the court date and time. If services are required in less than two weeks, the retainer is payable immediately.

In the event court is postponed or cancelled with less than 48 hour notice there will be no court retainer deposit refund. If more than 48 hour notice of postponement or cancellation **HALF of the retainer** will be returned. The stated fees are outside standard practice and subject to change.

Additional requests that require clinicians’ participation prompted by client including but not limited to phone calls/emails/conferences/that occur outside your scheduled appointment time is at the rate of **$100.00 per hour,** including any preparation time needed for school conferences/court subpoena preparation.

**FMLA paperwork or reports requested** for other than judge-signed court orders or to medical entities, requires a **$40.00 fee PAID IN ADVANCE**, with a minimum for 10 days to complete. Expedited requests (sooner than 10 days) the **fee is $60.00.**

**Professional Records:** When records are requested it must be in writing accompanied by a release of information with your signature. Records ae protected and certain exclusions may apply. There will be no fee for your primary physician or most health care providers for continuation and continuity of services/health record exchange. For all others, including client/client attorney or other authorized changes, $35.00 for records and $.25a page, for any records containing over 20 pages, including intake packet and other documents such as progress notes and releases of information. SCC reserves the right to allow for 14 days to properly review records and releasing determined records.

Clinicians and SCC will adhere to the law and confidentiality standards and are compliant with HIPAA as well as Indiana state law and Federal law; abiding by codes and set practice designed for each specific population and mental and substance abuse health records.

**Informed Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, voluntarily consent to receive counseling services from Stone City Counseling, Inc’s mental health providers (Sharon Adams, MSW, LCSW; Mindi Robinson, MSW, LCSW; Wanda Harper, MS Ed., CADAC II, LCAC; Blake Keithley MS Eds., LMHC; Marsha R. McCarty, PHd., HSPP; Sara Corry, LMHC; Karmon Nigg, LMHC, Alexa Howder, MSW, LSW, Kristin Cummings, MS, LMHC, Heidi Nuest LMHC-A) as defined in Indiana law, for problems associated with emotional, behavioral, addiction/substance abuse or other mental health issues. I understand I am consenting only to the mental health services that these providers are qualified to provide:

1. The scope of provider’s license, certification and training in mental health.
2. The scope of license, certification and training of those mental health providers directly supervising the services received by the patient.

I understand the services offered will consist of an interview process to assess the nature of the problem(S) and ongoing counseling to help resolve personal aspects of mental health issues. In some instances a referral will be made to a psychiatrist to evaluate the need for medication or review current medications or to other mental health providers of expertise/settings. Such process of referral will be reviewed between client and therapist and determined if appropriate and agreeable.

1. I will be given a clear description from my mental health provider regarding the problem, diagnosis, strengths, limitations and treatment plan proposed. I will engage in developing goals and the treatment plan.
2. I will be given a clear recommendation for the types of treatment recommended, such as: individual/family/group/couples/addictions/psychiatric referral or a combination of series. Dates, times and sessions will be disclosed and discussed with the therapist.
3. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my therapist may want to discuss this with me, but that I reserve the right to stop treatment. Furthermore, I understand that my therapist may make diagnostic and treatment recommendations with which I do not agree.
4. I understand that my therapist cannot guarantee results. They can clearly help me derive at goals and objectives and discuss continuation and discontinuation of mental health treatment.
5. I understand that there may be risks in participating in mental health services. These may include, but are not limited to: addressing painful emotional experiences or inconveniences due to costs/fees for services. I am aware that I can discuss any unforeseen risks vs benefits with my therapist at any time.
6. I understand that in the case of an emergency SCC does not have a 24 hour emergency hotline and any calls made after office hours or in the event for which a clinician cannot be reached, all clients are immediately referred to the local emergency room. I understand that in Lawrence County there are currently two emergency rooms, one at IU Health and one at St. Vincent Dunn Hospital. If those are not options then utilizing 911 is the next option.
7. I understand that if I have a grievance, I am to try and speak with my therapist. If this is not satisfactory or the grievance is against the therapist, I will utilize the information located in policy and procedure of SCC for making contact with the CEO Sharon Adams, MSW, LCSW, or her delegated staff.
8. I have the right to discuss my bill, payments and insurance information with the provider assistants in the billing office. While insurance is filed as a COURTESY I understand that it is not a guarantee for/of payment.

**Discharge Plan for Treatment Completion and/or Non-Compliance**

Client agrees to participate in the development of the treatment plan and goals and has agreed to a discharge plan/conclusion of treatment with therapist. This includes but is not limited to a closure session upon meeting goals and/or being referred to other sources Client agrees to have discussed and participate in any concerns about discharge from treatment including policy related to non-compliance and discharge.

1. Upon conclusion of the goals identified in the treatment plan, that will be developed between client and therapist, treatment may be concluded. Any necessary referrals to outside sources will be made.
2. Upon a break or conclusion of treatment any additional services provided by Stone City Counseling, Inc will require a new evaluation. Such new evaluation will occur in the following events:
3. If client and therapist agree and conclude services
4. If client stops attending treatment for more than 60 days
5. If client is non-compliant as evidenced by missing appointments/arrivals late too frequently resulting in dismissal or refusing to participate in treatment per original treatment agreement.

Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Use and disclose Protected Health Information (PHI)**

**HIPAA Privacy Practices disclosure:**

When a staff of Stone City Counseling, Inc examines, diagnoses, treats or refers you, they will be collecting what the law calls Protected health Information (PHI). This information is used to decide on what treatment is best for you. That information is shared with your insurance authorization department/case management department or delegated representative to receive authorization for treatment. It may also used for the billing department/clearinghouse and or other business and or government entity to ensure payment.

This notice is required by federal law, the health insurance privacy and portability act (HIPPA). This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Receptionist will have an extended copy of this form if you wish to speak to her about it. You may also access this via [www.cms.hhs.gov/](http://www.cms.hhs.gov/)

1. Uses and disclosure for treatment, payment and health care operations

Stone City Counseling, Inc (SCC) must have your written authorization to use or disclose your protected health information (\_HI) for any reason (with some exceptions discussed in section III) including for treatment, payment and health care operations purposes.

1. Other uses and disclosure requiring authorizations

SCC may use or disclose PHI for purposes outside of treatment, payment or health care operations when you give permission by signing an authorization also described as “release of information” **You may revoke authorization at any time, provided each revocation is in writing**. You may not revoke an authorization to the extent that it has been used to obtain insurance coverage. The law provides the insurer the right to contest the claim under the policy.

1. Uses and disclosure without authorization

SCC may use or disclose PHI without your consent or authorization in the following circumstances: child abuse, adult and domestic abuse, judicial and administrative proceedings, and serious threat to health or safety. (IF you would like a description of these circumstance please speak to or schedule a time to speak with CEO Sharon Adams, LCSW.)

1. Stone City Counseling Duties

SCC is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect PHI. SCC reserves the right to change the privacy policies and practices described in this notice. Unless you are notified by SCC by sch changes we will abide by the terms currently in effect.

1. Complaints

If you are concerned that SCC has violated your privacy rights or you disagree with a decision that has been made, you may contact the US Department of Health and Human Services for Indiana.

I hereby authorize Stone City Counseling, Inc to release any information on behalf of Stone City Counseling, Inc including my mental health record, which may include information pertaining to drug or alcohol matters, acquired in the course of examination or treatments to the managed care organizations(S), insurance company(s), and primary healthcare provider . The purpose for this authorization and release is to secure payment for services rendered to me, a designated dependent under my healthcare policy, or to the person specified herein and for whom I am the court appointed guardian or as the healthcare representative under a properly executed and existing healthcare power of attorney designation. I understand this release is subject to revocation IN WRITINTG at any time except to the extent that Stone City Counseling, Inc has already taken action in reliance thereon, including provided services. This authorization will terminate upon the conclusion of the course of examination or treatment with SCC and the settlement of my account with our billing department.

By signing this section you fully understand and agree with the above content and purposes for sharing PHI under such provision and that, if need be, the information has orally been explained to you by a delegated staff of Stone City Counseling, Inc.

**Prohibition on re-disclosure:** SCC will maintain all incoming records in the same manner as all other records are held. SCC does not redistribute nor transmit in any format records they have received from other agencies/mental health providers or health care physicians. Each fax and email have an attached clause on prohibition of re-disclosure under the federal guidelines. Additionally, SCC informs recipient, not intended to receive such materials, how to contact sender of such an event.

**Confidentiality Notification of Alcohol and Drug Abuse Patient Records**

In accordance with federal and state laws, the confidentiality of alcohol and drug abuse patient records maintained by Stone City Counseling, Inc is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient s engaged in any services of SCC unless:

1. The client consents in writing
2. The disclosure is allowed by a court order and subpoena
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel fo research, audit or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

You understand that confidentiality of mental health records are also protected and have the following limited exceptions:

1. **Suicide/Homicide:** When there is risk of imminent danger to self or others, the clinician is ethically bound to take necessary steps to prevent such danger. Such steps are to follow through with information to proper authorities when such imminent harm presents.
2. **Child/Adult/Disabled:** When there is suspicion or alleged abuse of Children, the elderly or the disabled, the clinician is required by law to report such to the proper authorities.
3. **Court order/Subpoena:** Mental health providers can be required to relinquish a copy of written mental health records to appropriate courts They may be subpoenaed to testify in court without your consent. IN such cases a proper hearing is held and providers make every effort to inform clients of this development.
4. **Minors:** Certain situations will require mental health providers to inform parents/guardians.
5. Billing purposes: Reference the HIPAA form attached to this intake packet, and be advised that diagnosis is required to bill insurance and some carriers may require additional records.

**(See: 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42CFR part 2 for Federal regulations. Approved by the Office of Management and Budget under control number 0930-0099)**

The prohibitions and terms of the rules concerning disclosure of patient records or information contained therein apply to all individuals including but not limited to any personnel, interns, volunteers, researchers, auditors and any of same of Stone city Counseling, Inc who have access to such records or information. These prohibitions and terms continue to apply to such individuals with respect to such records or information after the termination of their employment or other relationship that permitted such access.

**By signing** you agree to comply with SCC’s requirements on confidentiality and acknowledge that you have received and reviewed a copy of this notice, have been given an opportunity to ask question and may receive a copy of this form, if requested, and have been given information on accessing a copy of the Indiana and/Federal laws.

**Clients Rights & Responsibilities**

**Clients of SCC have the right:**

1. To receive quality care with efficacy based treatment modalities and trained professional clinicians
2. To be treated with dignity and respect in a secure and confidential setting
3. To be free of physical, emotional and verbal abuse or neglect
4. To be free of restraints, seclusions, or other forms of confinement
5. To be provided benefits and risks of treatment
6. To participate in developing the treatment plan
7. To be involved in discharge planning
8. To receive services regardless of age, color, disability, gender, language, race, sexual orientation, or spiritual believe. In such incidents of language barrier a client is welcome to facilitate interpreter.
9. To terminate treatment at any time
10. To beet with therapist and discuss medical records and to request copies
11. To file grievances without impact or corruption to treatment
12. To work with clinicians who adhere to all federal, state and professional obligations to confidentiality, privacy and any other respective legislation or oath related to mental health
13. To be privileged to the clinician training, qualifications and credentials.
14. To be informed of all resources for which Stone City Counseling, Inc is aware

**Clients of Stone City Counseling Inc, have the responsibilities:**

1. To treat the staff in non-threatening ways
2. To present free of violence
3. To be free of weapons at all appointments
4. To come to all appointments on time and or cancel at a minimum 24 hour notice.
5. To adhere to the agreed upon treatment plan
6. To keep confidential who they see and what is shared in terms of information in groups or seeing someone else at the clinic
7. To pay for the agreed upon fee
8. To be from the effects of drugs or alcohol

**BIO/PSYCHO/SOCIAL DATA**

**\*\*\*Put “N/A” or “don’t know” or draw a line through any questions unrelated to you\*\*\***

Relationship Status (please circle): Married Partnered Divorced Single Widow(er) Separated

Number of times Married\_\_\_\_ Divorced\_\_\_\_ Cohabited \_\_\_\_ How long at current residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current support people/support systems in your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all household members in the chart below:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Where are you employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unemployed? Last job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest level of education you have completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications—list current, including those not prescribed.

|  |  |  |
| --- | --- | --- |
| Name | Dosage/how long have you taken it | Prescribing doctor |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List any allergies/medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use History—Past and Present**

Please list substances that you have used **within the past year:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list substances you have experimented with/used in the past: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is there a family history of substance abuse? (mother, father, brother, sister, grandparents) YES NO

Have any family members experienced mental/emotional or behavioral illness or attempted or committed suicide: YES NO

**Were your parents married?** YES NO If not, or if divorced, what age were you when they were no longer together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How may brothers \_\_\_ How many sisters \_\_\_ What is your birth order? \_\_\_\_\_\_\_ Are you parents living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you participated in counseling in the past? YES NO

**Clinical / Diagnostic Data**

**Please list symptoms you are CURRENTLY experiencing. WHEN did symptoms begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Suicidal Ideation (SI) |  | Smelling Items |  | Impulsive |  | Problems with drugs/alcohol |
| Homicidal Ideation (HI) |  | Intrusive or Recurring Thoughts |  | Poor Self Care |  | Feelings of Guilt |
| SI with a Plan |  | Thoughts of Self -harm |  | Anxiety Attacks |  | Hopelessness |
| HI with a Plan |  | Anger/Irritability |  | Crying More Frequently |  | Hallucinations |
| SI with a Plan and Intent |  | Trouble Concentrating/focusing |  | Depression |  | Racing Thoughts |
| HI with a Plan and Intent |  | Weight Loss/Gain |  | Low Self-Esteem/Worthless |  | Nervous Around People |
| Hearing things that aren’t there |  | Changes in Appetite |  | Dizziness |  | Memory Problems |
| Seeing things that aren’t there |  | Difficulty with Sleep |  | Unable to Perform Tasks |  |  |