Family Concern Counseling

NEW CLIENT INTAKE

Office Use Only:
Counselor's Name:______________________ ICD-10 Code:____________ Date: ____________

Complete and accurate information is required. All information will be kept confidential.

CLIENT INFORMATION

Name—First: ________________ Nickname: ________ M.I.___ Last:____________________

Address: ____

City: ______________________________ State: ______ Zip: __________

Date of Birth: ____________________ SS#: ____________________

Sex ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Cell Phone: ____________________ Work Phone: ____________________

Home Phone: ____________________ Email Address: ____________________

Primary Care Physician____________________________ Phone: ______________

Psychiatrist/APRN/NP ____________________________ Phone: ______________

APPOINTMENT REMINDERS

Please send appointment reminders via: ☐ Text Message—cell ph# provided ☐ Email—provided
☐ Phone Call—Best number to call____________________

☐ *No Reminder is Needed*

EMPLOYMENT/STUDENT STATUS

☐ Employed-FT ☐ Employed-PT ☐ FT Student ☐ PT Student ☐ Other ______________

Place of Employment/School: ______________________ Phone: ______________

EMERGENCY CONTACT PERSON

Person to contact in case of an EMERGENCY

Name: ______________________ Relationship to Client:______________

Cell Phone: ______________________ Other Phone: ______________

CANCELLATION POLICY

If you need to cancel your appointment, we request a 24-hour notice. Appointments that are cancelled with less than 24-hour notice will be charged a $25.00 cancellation fee. If you do not show for your appointment you will be charged a $25.00 no show fee. I understand and agree to abide by this policy.

______________________________ ______________
Signature *Date*

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RESPONSIBLE PARTY—*Name and address of person responsible for any balance NOT COVERED by insurance:*

☐ Same as Client
☐ Other Name: ____________________ Date of Birth: ______________ SS#: ______________

☐ Same as Client
Address: ____________________ City: ______________ State: _____ Zip: ________

Cell Phone: ____________________ Home/Work Phone: ____________________

INSURANCE—*Include copy of front and back of insurance card:*

PRIMARY INSURANCE

PRIMARY Insurance: ____________________ Phone: ______________

Subscriber/ID#: ____________________ Group#: ______________

SUBSCRIBER—CARD HOLDER INFORMATION

☐ Same as Client ☐ Same as Responsible Party ☐ Other

Client Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) ______________

Subscriber Name: ______________ Date of Birth: ______________ SS#: ______________

☐ Same as Client
Address: ______________ City: ______________ State: ________ Zip: ______________

PLACE OF EMPLOYMENT: ____________________ Phone: ______________

SECONDARY INSURANCE

SECONDARY Insurance: ____________________ Phone: ______________

Subscriber/ID#: ____________________ Group#: ______________

SUBSCRIBER—CARD HOLDER INFORMATION

☐ Same as Client ☐ Same as Responsible Party ☐ Other

Client Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) ______________

Subscriber Name: ______________ Date of Birth: ______________ SS#: ______________

☐ Same as Client
Address: ______________ City: ______________ State: _____ Zip: ______________

PLACE OF EMPLOYMENT: ____________________ Phone: ______________

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment and am aware that some insurance carriers require supervision [i.e. Medicare, some Medicaid plans, etc.]. I hereby assign to the provider all payments for medical services rendered to my dependents or myself and acknowledge that collaborative consultation and supervision may be required by my insurance company. **I accept responsibility for any amount NOT covered by insurance.**

____________________ ______________

Signature of Client, Parent, Guardian or Personal Representative *Date*

____________________ ______________

Please print name of Client, Parent, Guardian or Personal Representative *Relationship to Client*

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NEW CLIENT INTAKE

Please check all that apply.

In the last year, I have experienced concerns about the following checked reason(s) for counseling **at least once**:

REASON(S) I AM COMING TO COUNSELING					
☐ Abandonment	☐ Bulimia	☐ Elder Care	☐ Inactivity	☐ Oppositional	☐ Shame
☐ Abuse	☐ Child Care	☐ Employment	☐ Inattention	☐ Pain	☐ Sibling Conflict
☐ Affair	☐ Codependency	☐ Emptiness	☐ Inhibition	☐ Panic	☐ Social Skills
☐ Alcohol	☐ Compulsions	☐ Enabling	☐ Impulsivity	☐ Rage	☐ Sleep
☐ Alienation	☐ Conduct	☐ Family Conflict	☐ Irritability	☐ Rationalization	☐ Somatization
☐ Anger	☐ Crisis	☐ Fear	☐ Isolation	☐ Rejection	☐ Stress
☐ Anorexia	☐ Delusions	☐ Grades	☐ Jealousy	☐ Relationships	☐ Trauma
☐ Anxiety	☐ Denial	☐ Grandiosity	☐ Legal Problem	☐ Resistance	☐ Trust
☐ Avoidant	☐ Depression	☐ Grief	☐ Marital	☐ Ruminative	☐ Worry
☐ Appetite	☐ Disability	☐ Guilt	☐ Medical	☐ School Problem	☐ Other, please list:
☐ Blended Family	☐ Disorganized	☐ Hallucinations	☐ Memory Loss	☐ Self-Absorption	•
☐ Body Image	☐ Distractible	☐ Histrionic	☐ Mood Swings	☐ Self-Esteem	•
☐ Bonding	☐ Divorce	☐ Hyperactive	☐ Obesity	☐ Separation Anxiety	•
☐ Boundaries	☐ Drugs	☐ Idealization	☐ Obsessions	☐ Sexual Abuse	•

The following person(s) will be supporting me through the counseling process:

SUPPORT				
☐ Spouse	☐ Nuclear Family	☐ Extended Family	☐ Close Friend	☐ Other, please list:
☐ Church/Mosque/Temple	☐ 12-step	☐ Service System	☐ Group of Friends	•

CONSENT FOR TREATMENT

I, the undersigned, agree, and consent to participate in the mental health services, as defined in Indiana law,

offered by ***(counselor's name)***____ a

❑ Clinical Psychologist
❑ Licensed Marriage and Family Therapist
❑ Licensed Clinical Social Worker
❑ Master's Level Counselor/Therapist/Social Worker
❑ Licensed Mental Health Counselor
❑ Counseling Intern ❑ Practicum Student

I understand that I am consenting and agreeing only to those mental health services that the above-named provider is qualified to provide within: (a) the scope of the provider's license, certification, and training, or (b) the scope of license, certification, and training of those mental health providers directly supervising the services received by me, the client.

❑ As an intern/practicum student, I am under the supervision of a licensed therapist.
If you have any questions about my services, please contact my supervisor:

______________________ @ ______________________ -or- (219)______________________
name of supervisor email phone

Signature for Consent to Treatment

______________________________ ______________
Client Signature *Date*

______________________________ ______________
Guardian Signature *Date*

______________________________ ______________
Provider Signature *Date*

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