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*

Family Concern Counseling

New Client Intake

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*

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*