Intake Paperwork

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Today's Date: (mm/dd/yyyy) _______________ Name: ______________________________Pronouns:___________
Form filled out by:__________________________________ Date of Birth: __________ Age:____ Gender:________
Residential Street Address: ____
Primary Phone #: ______________________ May I leave a message for you at this number?_________________
Email address: __________________________________ Is it okay to use email to contact you?_______________
Preferred method of contact: _____________ Preferred times to contact you if by phone: ___________________
Legal Guardian(s) (if applicable): ______________________ Referral Source:_____________________________

Emergency Contact Information

Emergency Contact Person(s): __________________________________ Phone #: _________________________
Emergency Contact Person(s) Relationship to Client: ____

Payment Information

I need assistance with the fees for services?*:* ☐ Yes ☐ No ☐ Unsure

Will you be paying by? ☐ Cash ☐ Check. ☐ Venmo / Venmo Username:____________________

Do you have out of network insurance benefits that might apply ☐ Yes ☐ No ☐ Unsure

Presenting Problem

Please describe what brings you in today____

____

How long have you been experiencing this problem? ☐ Less than 30 days ☐ 1-6 months ☐ 1-5 years ☐ 5+ years
Rate the intensity of this problem from 1 to 5 (1 being mild, 5 being severe):____
How is the problem interfering with your day to day functioning?____

____

Are you currently or have you, in the last 30 days, experienced any of the following symptoms:

☐ Sadness
☐ No Motivation
☐ Not Hungry
☐ No Need for Sleep
☐ Suspicious
☐ People Out to Get Me
☐ Easily Startled
☐ Hopeless/Helpless
☐ Can't Be in Crowds
☐ Lack of Interest
☐ Prefer Being Alone
☐ Talk Too Fast
☐ Hearing Things
☐ Feeling Nervous
☐ Avoidance
☐ Sleep Too Much
☐ Thoughts of Dying
☐ Irritable/Angry
☐ Impulsive
☐ Seeing Things
☐ Fearful
☐ Re-occurring Nightmares
☐ Fatigue/No Energy
☐ Guilt
☐ Can't Sleep
☐ Can't Concentrate
☐ Have Special Powers
☐ Panic Attacks
☐ Poor Memory
☐ Feel Worthless
☐ Too Much Energy
☐ Restless/Can't Sleep
☐ People Watching Me

Mental Health Information

Have you ever been in counseling/therapy before? __________ When? __________________________________
If yes, did you find it helpful or effective? ____
Are you currently receiving mental health services? If yes, please list name of practitioner and type of services you are receiving: ____
Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed?

____

____

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? If yes, please fill out 'Other' and include date(s), method(s), and age at time of attempt: ☐ Yes ☐ No Other:____

Do you have a history of abuse/neglect (*please explain)*:____

Personal, Family, and Relationships

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed For how long? _____

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?________________________

Are you sexually active? ☐ Yes ☐ No How would you identify your sexual orientation?____________________

If married/partnered: What is your spouse or significant other's occupation? ___________________________

Describe your relationship with your spouse or significant other:____________________________________

Have you had any prior marriages? ☐ Yes ☐ No. If so, how many? ______How long? ___________________

Do you have children? ☐ Yes ☐ No If yes, list ages and gender:

____

____

Describe your relationship with your children:____

List everyone who currently lives with you: ____

____

Who is in your family? (name parents, brothers, sisters, children, etc.)____________________________

____

Has any significant person/family member entered or left your life in the last 90 days? ☐Yes ☐No

	Good	Fair	Poor	Close	Stressful	Distant	Other
How are the relationships in your family?..	☐	☐	☐	☐	☐	☐	☐
How are they in your support system (friends, extended family, etc.?).................	☐	☐	☐	☐	☐	☐	☐

(Please mark all that Apply)	Conflict	Abuse	Stress	Loss	Other
Are there any problems in your family now?..	☐	☐	☐	☐	☐
Were there any problems with your family in the past?..	☐	☐	☐	☐	☐
Are there any problems in your support system now?……………………………………..	☐	☐	☐	☐	☐
Were there any problems with your support system in the past?..................................	☐	☐	☐	☐	☐

What is your marital status now? ☐Single ☐Married ☐Living as Married ☐Divorced ☐Widowed ☐Never Married

Have you ever had problems with marriage/relationships? ☐Yes ☐No ☐NA

If yes, please check why: ☐Stress ☐Conflict ☐Loss ☐Divorce/Separation ☐Trust Issues Other______________

Do you have any close friends? ☐Yes ☐No ☐NA

Do you have any problems with friendships? ☐Yes ☐No ☐NA

Do you get along well with others (neighbors, co-workers, etc.)?☐Yes ☐No ☐NA

What do you like to do for fun?____

What community involvement(s) do you currently have? (ie groups, clubs, activities, religious affiliation):______

____

Have you ever been arrested? _______Do you have any pending legal problems at this time?_____________

Do you belong to a particular religion or spiritual group? ☐Yes ☐No Name:______________________________

If yes, what is the level of your involvement? ____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

Substance Use

Which substances do you currently use or have you previously used? *(Mark current with a 'C', Past with a 'P', and 'B' for both current and past):*

☐ None ☐ Speed ☐ Inhalants ☐ Benzodiazepine
☐ Unknown ☐ Cocaine ☐ Marijuana ☐ Barbiturates
☐ LCD ☐ Caffeine ☐ Morphine ☐ Methamphetamine
☐ PCP ☐ Heroin ☐ Mushrooms ☐ Prescription Drugs
☐ Crack ☐ Opioids ☐ Alcohol ☐ Other *(please explain)*: ______________________________
☐ Crank ☐ Tobacco ☐ Amphetamine

Have you ever been in substance abuse treatment? __________ Where/When? ___________________________

Is there a history of substance use in your family? *(please explain):*_______________________________

____

Medical Information

Who is your Primary Care Physician?__________________________ Phone #:___________________

Primary Care Physician's Practice Name/City: ____

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

☐ Asthma
☐ Brain Injury
☐ Digestive Disorders
☐ Breathing Problems
☐ High Blood Pressure
☐ Arthritis
☐ Thyroid Disorder
☐ Pregnancy
☐ Miscarriage
☐ Allergies
☐ Epilepsy
☐ Cancer
☐ Diabetes
☐ Multiple Sclerosis
☐ Surgery
☐ Headaches
☐ Serious Accident
☐ Sexually Transmitted Disease
☐ Sleep Disorder
☐ Heart Disease
☐ Seizures
☐ Surgery
☐ Sleep Disorder
☐ Hearing Problems Surgery
☐ Other Concerns:
____
____
____
____
____

Please list any prescription medications you are currently taking, what they are for, and dosage:_____________

____

____

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

____

____

How has your sleep been in the last 7 days? *(check all that apply)*

☐Restless ☐ Difficulty falling asleep ☐Difficulty staying asleep ☐ Satisfying ☐ Refreshing ☐Got enough ☐ Other:________________

How many hours of sleep you average each night?______ How many do you need to feel refreshed?________

Are there ever periods where you need much less sleep than usual?___ If so, how much do you need at that time?_____

How often do you exercise? ______________ What do you do for exercise?______________________________

What do you do for relaxation?____

Education

Education Level *(please check highest level completed):*

☐No Formal Education ☐K-5 ☐6-8 ☐9-12 ☐GED ☐Associate’s Degree ☐Bachelor’s Degree ☐Masters Degree ☐PhD ☐Other

If still attending, current school/grade:________________ Vocational School/Skill Area:____________________

College/Graduate School – Years Completed/Major: ____

Employment

Are you currently employed? ☐ Yes ☐ No

Current Employer:________________________________ Profession: ___________________________________

If you have worked in the past, what did you do for work?____

____

How do you feel about your employment?____

Acknowledgment of Disclosure Statement

By signing this document, I confirm that I have received a copy of the required disclosure information, and that I have read and understood this information. I agree to participate in and/or have my child(ren) participate in counseling from Heather A. Astill, LSCSW, MSW. This agreement shall remain in effect until either the client or the therapist, or both terminate treatment.

______________________________	______________________________	____________
Printed Client Name	Client Signature	Date

______________________________	____________
Heather A. Astill, LSCSW	Date

Fee Agreement

I, agree to pay $ ____ per 45-50 minute therapy session or $____ per 60 minute session. Late cancellations (less than 24 hours notice unless it is an emergency) and “no-shows” will be billed as half the session fee and must be paid at the next scheduled appointment or within 15 days, whichever comes first. This will not be billed to your insurance or to another party.

I understand that payment is to be made at each session unless other arrangements have been made. Telephone and teletherapy appointments are billed at the same rate as office sessions. Payment for telephone appointments must be made within 15 days, or at the next scheduled appointment, whichever comes first. I also understand that I will be billed $20.00 for checks returned for insufficient funds.

______________________________	______________________________	____________
Printed Client Name	Client Signature	Date

______________________________	____________
Heather A. Astill, LSCSW	Date

Patient-Therapist Confidentiality and the Limits to Confidentiality

Patient confidentiality is a vital component of psychotherapy. It is extremely important that patients feel secure that what they discuss in therapy will not be shared. There are three circumstances in which a therapist is required to report confidential information to state public welfare officials:

1. Child abuse
2. Physical abuse of an elder or dependent adult living in the home
3. Expressed intent to harm oneself or another person

I have read, understand and agree to the terms stated herein.

______________________________	______________________________	____________
Printed Client Name	Client Signature	Date

______________________________	____________
Heather A. Astill, LSCSW	Date