

Intake Paperwork

Heather A. Astill, LSCSW, MSW hastill.therapy@protonmail.com

Today's Date: (mm/dd/yyyy) _____ Form filled out by: _____
Name: _____ 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

Will you be paying by cash, check, or 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:

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

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? (please circle)	Currently	Past	Never
Have you ever or are you currently contemplating suicide?	Currently	Past	Never
Have you ever or are you currently contemplating harming another person?	Currently	Past	Never

Have you ever attempted or contemplated suicide? If yes, please fill out 'Other' and include date(s), method(s), and age at time of attempt (please circle): Yes No Other: _____

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

Is there a family history of mental health concerns? (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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How are they in your support system (friends, extended family, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

(Please mark all that Apply)

	Conflict	Abuse	Stress	Loss	Other
Are there any problems in your family now?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Were there any problems with your family in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Are there any problems in your support system now?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Were there any problems with your support system in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

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 Other: _____

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 recreationally? (Mark current with a 'C', Past with a 'P', and 'B' for both current and past):

<input type="checkbox"/> None	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Benzodiazepine.	<input type="checkbox"/> Speed	
<input type="checkbox"/> Inhalants	<input type="checkbox"/> Crack/Crank	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Amphetamine	<input type="checkbox"/> Mushrooms	<input type="checkbox"/> LSD	<input type="checkbox"/> PCP
<input type="checkbox"/> Morphine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Opioids	<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Other: _____		

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:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sleep Disorder | |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Chronic Fatigue Syndrome | |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Disorder | |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Surgery | <input type="checkbox"/> Hearing Problems | |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ | |

What more would be helpful for me to know about the aforementioned conditions?: _____

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 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 do 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? _____

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 – School name/Years Completed/Major: _____

Employment

Are you currently employed? (please circle) Yes No Current Employer: _____

Profession: _____ If you have worked in the past, what did you do for work? _____

Financial Assistance

(Mark all of those that apply):

- | | | | | | |
|--|-----------------------------------|---|-------------------------------|---|--|
| <input type="checkbox"/> Food Stamps/EBT | <input type="checkbox"/> TANF | <input type="checkbox"/> SSI | <input type="checkbox"/> SSDI | <input type="checkbox"/> SSA (retirement) | <input type="checkbox"/> Other Retirement Income |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare | <input type="checkbox"/> General Assistance | | | |

Thank you for completing this form!

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, LCSW-C, 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 the fees as stated in the disclosure statement. (Most commonly: \$140 for intake/60 minute sessions and \$120 for 45-50 minute sessions).

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.

I understand that payment is to be made at each session unless other arrangements have been made. Teletherapy sessions are billed at the same rate as office sessions. 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	