Confidential Client Intake Information

Welcome to my practice! Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so. If you have any questions about this information, please feel free to ask me about it.

Your complete name: ____

Address:____

City: ____________________ State: _____ Zip/Postal Code: _______________

Home phone: ______________________ Cell phone number: __________________

Personal E-mail Address: ____

Referred by: ____

Please check the type(s) of appointment reminder you would like to receive or decline:

Voice ____ E-mail ____ Text ____ I do not wish to receive reminders: ______

Age: _______ Birthdate: _______ Birthplace: ____________________________

Education (grade completed, any postsecondary): _____________________________

Current Occupation: ____

Do you practice a religion: ___ Yes ___ No If yes, what is your faith? _________________

If no, do you consider yourself to be spiritual? ___ Yes ___ No

Person to alert in the event of medical emergency: ___________________________

Relationship to you: ____________________ Phone: _________________

Family Doctor: ____________________________ Phone: _________________

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name: ____________________________ Age: ___ Yrs in relationship: _____

Children (gender, age): ____

Please describe your current living situation. Do you live alone, with others. with family, etc…

____

Please describe any significant current or past medical problems: _____________________________

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Do you drink alcohol? ___Yes ___ No

If yes, Please describe how many drinks you have a week. ____________________________________

Do you use recreational drugs? ___ Yes ___ No

Do you have suicidal thoughts? ___ Yes ___ No

Have you ever attempted suicide? ___Yes ___ No

Has anyone in you family attempted suicide? ___Yes ___ No

Do you have thoughts or urges to harm others? ___ Yes ___ No

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

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Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months/years you saw them, and the nature of the difficulty at the time.

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Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please give the dates and the nature of the difficulty at the time: ________________

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Is there a history of psychological distress in your family? If yes, please describe who and your understanding of the history.____

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Please indicate any of the following you have experienced in the past six months:

Increased appetite ___ Yes ___ No
Decreased appetite ___ Yes ___ No
Trouble concentrating ___ Yes ___ No
Difficulty sleeping ___ Yes ___ No
Excessive sleep ___ Yes ___ No
Low motivation ___ Yes ___ No
Isolation from others ___ Yes ___ No
Fatigue/low energy ___ Yes ___ No
Low self-esteem ___ Yes ___ No
Depressed mood ___ Yes ___ No
Tearful or crying spells ___ Yes ___ No
Hopelessness ___ Yes ___ No
Loss of interest in Activities ___ Yes ___ No
Anxiety ___ Yes ___ No
Fear ___ Yes ___ No
Panic ___ Yes ___ No

Please describe any additional symptoms you have experienced in the past six months: __________

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____

Please describe any physical difficulties, disabilities, or illnesses you have experienced or are currently experiencing. ____

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In your own words, what is the nature of the concern you wish to address in counseling, i.e., What has brought you to counseling? Is there something specific, such as a particular event? Please be as detailed as you can.

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Please list your strengths. ____

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Counseling/psychotherapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

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Please indicate how you plan to pay for your counseling sessions:

Private Pay ___ (You will be responsible for the designated fee and do not plan to file insurance.)

Insurance ___

If you plan to use your insurance to help pay for your counseling, please complete the sections below and sign the authorizations. If you do not plan to use insurance, please sign immediately below and skip to page 6 to sign the acknowledgements and agreements.

Client Signature: ______________________________________ **Date:** _________________________

Insurance Information

Policy Holder Name: ____ DOB: __________

Address: ____

Phone: ___________________________ Employer: ________________________________

Insurance Company: ____

Policy No. _________________________ Group No. ______________________________

Copay: _______ Co-insurance: _______ Deductible? ___ Yes ___ No $_______

Assignment of Benefits

I hereby authorize my insurance company to make payments directly to Abigail S. Holbrook, MSW, LCSW for counseling/psychotherapy services. I accept personal responsibility for the deductible amount and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and they be accepted as valid as the original.

Client Signature:_________________________________ Date:_______________

Authorization For Release of Information to Insurance Providers

I hereby authorize the release of Protected Health Information relating to all claims for benefits submitted for me to the insurance company indicated above. I further agree and acknowledge that my signature on this document authorizes Abigail S. Holbrook, MSW, LCSW, LLC to submit claims for payment of services rendered without obtaining my signature for every claim and that I will be bound by this signature as though I had personally signed each claim.

Client Signature: ______________________________________ Date: ________________

Acknowledgement of Receipt of Privacy Practices Notice:

I hereby acknowledge that I have received or have been given an opportunity to read a copy of Abigail S. Holbrook, MSW, LCSW, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Abigail S. Holbrook, MSW, LCSW at 706-424-4814.

Client Signature: ______________________________________ Date: ________________

❑ **Patient/Client Refuses to Acknowledge Receipt**:

Therapist Signature: ___________________________________ Date: ________________

Late Appointment Cancellations or Missed Appointment Agreement

By signing below, I am acknowledging that I have read, understand, and agree to abide by Abigail S. Holbrook, MSW, LCSW, LLC's around late appointment cancellations and missed appointments. I accept I am responsible for paying the full session fee of $110 for any missed appointments or appointments that are cancelled or rescheduled in less than 24 hours of the scheduled appointment time. Legally, insurance cannot be filed for any scheduled appointments that are missed. The fee will be collected at the next scheduled appointment or a statement mailed if no further appointments are scheduled.

Client Signature: ____________________________________ Date: _________________________

Practice Policies Agreement and Informed Consent for Counseling:

Practice Polices Agreement:

By signing below, I am acknowledging that I have read, understand, and agree to abide by the ***Practice Policies*** *outlined in the attached document, having had any questions answered to my satisfaction.*

Informed Consent:

By signing below I am acknowledging that I have read the ***Information About the Therapeutic Process*** *and understand the risks and benefits of counseling, the nature and limits of confidentiality. I agree to abide by the contents and terms of the document and I consent to participate in counseling/psychotherapy with Abigail S. Holbrook, MSW, LCSW. I understand I may withdraw from counseling/psychotherapy at any time.*

Client Signature: ____________________________________ Date: ____________________

Therapist
Signature: ____ Date: ____________________