INITIAL PSYCHOTHERAPY INTAKE

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information. Please fill out this form and bring it your first session.

Part One:

Name:______________________________________ Date of Birth:__________ Age: ______
Last First M.I. MM/DD/YYYY

Name of parent or guardian (if under 18 years old): ______________________________
Last First M.I.

Address: ____
Street Address City State Zip

Ethnicity:________________ Marital Status: __________ Sex/Gender: ____________

Do you have a preferred name?__________________________ Do have a preferred pronoun? ______

Highest Level of Education: ____________________ Referred by: (if any) ________________

Home Phone: ( ) May we leave you a message? Yes No
Cell Phone: ( ) May we leave you a message? Yes No

E-Mail: ______________________________ May we email you? Yes No
**Please note: E-Mail correspondence is not considered to be a confidential medium of communication.*

Part Two:

History of Presenting Problem- please describe history of symptoms, onset, previous treatment:

____
____
____
____

Are you currently experiencing overwhelming sadness, grief or depression? No Yes
If yes, for approximately how long? ______________________

Are you currently experiencing anxiety, panic attacks, or phobias? No Yes
If yes, for approximately how long? ______________________

Past Psychiatric History- please describe prior treatment, symptoms, past diagnoses, & hospitalizations:

____
____
____
____
____
____

Have you experienced past suicide attempts? Please state how many times and the year in which it occurred:

____
____
____

If you have experienced a history of abuse, please circle: Verbal Physical Sexual Emotional
(*In session with your therapist, you will have an opportunity to discuss the history of abuse you have experienced*)

Family Medical & Psychiatric History- please circle and list family member(s):

Alcohol/Substance Abuse	yes/no
Anxiety	yes/no
Depression	yes/no
Domestic Violence	yes/no
Eating Disorders	yes/no
Weight Issues	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Personality Disorder(s)	yes/no
Bipolar Disorder	yes/no
Suicide Attempts	yes/no

Medical Conditions and History-
How would you rate your current physical health? Poor / Unsatisfactory / Satisfactory / Good / Very Good
How would you rate your current sleeping habits? Poor / Unsatisfactory / Satisfactory / Good / Very Good
Eating pattern/food issues: ____________________

Please describe current and past conditions, treatment, allergies, etc.:

____
____
____
____

Current medications- please describe dosage and frequency:

____
____
____
____

Substance use past and present- please include alcohol, illicit, prescribed and OTC abuse, withdrawal symptoms, blackouts, longest sobriety, do you drink alcohol more than 1x/week?, how often do you engage in recreational drug use?:

____
____
____

Psychosocial history- please describe past or current school/work issues, family history, relationships, financial, etc.:

____
____
____
____

Cultural Variables- please describe any cultural variables that may impact the therapeutic process:

____
____
____

Developmental History- please describe development milestones and/or delays:

____
____
____

Educational/Occupational History- please describe level of education, current/past employment:

____
____
____

Legal History- please describe arrest history, sentencing, DUI occurrences, incarceration, etc.:

____
____
____

Are you currently receiving or participating in any community resources? Please explain:

____
____
____

Do you consider yourself to spiritual or religious? Please explain:

____
____
____

What significant life changes or stressful events have you experienced recently?

____
____
____

What do you consider to be some of your strengths?

____
____
____

What do you consider to be some of your limitations?

____
____
____

What would you like to accomplish out of your time in therapy?

____
____
____
____

Privacy and Rights Acknowledgement

Patient Name:____ Date:___________________

Please read the following polices and initial below:

Initial_____ I have read and understand my **Patient Rights**, stating as a patient of Hope for a Better Tomorrow, I have specific rights that are enumerated in Wisconsin Statutes 51.61 and Wisconsin Administrative Code HHS 94.

Initial_____ I have read and understand the **Cancellation Policy** stating that I can be charged a $50.00 cancellation fee if I cancel my appointment with less than a 24 hour notice. (Unless due to illness or emergency)

Initial_____ I have read and understand my **Limits of Liability Policy** stating therapy services carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of my life are considered risks of therapy sessions.

Initial_____ I have read and understand my **Limits of Confidentiality** stating what I discuss during my therapy session are kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of my legal guardian. The following is a list of exceptions: Duty to Warn and Protect, Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Minors/Guardianship and Insurance Providers and Hope for a Better Tomorrow Clinician Collaboration

Initial_____ I have read and understand the **HIPAA** stating how therapeutic and medical information about you may be used and disclosed, your rights as a patient and ways for you to get additional information on our policies. Our clinic has always been very protective of your personal information. Under new federal regulations (HIPAA Privacy Act), we have adopted additional guidelines to ensure proper use, confidentiality, and disclosure of your health information.

By signing below, I am acknowledging that I have read and understand the above polices. Paper or electronic copies can be obtained per request.

____ ____________________

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person and offered them a copy of these polices.

____ ____________________

Administrative Signature Date

Payment Acknowledgement Agreement

Patient Name: ____ Date:_________

Please read the following statements and initial below:

Initial ____ I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility and will be subject to the therapists self-pay amount of $________. I understand that co-payment and deductible amounts may change depending on my mental health benefits within my insurance policy.

Initial ____ I understand that any unpaid services will be considered delinquent and will be sent to a collection agency.

Initial ____ I understand and agree that I will be charged a $50.00 cancellation fee if I cancel my appointment with less than a **24 hour notice**. (Unless due to illness or emergency)

Initial ____ I understand and agree to the $3 fee when using a credit or debit card other than medical cards to pay for any and all services. Cash and check are no charge. There will be a $20+ fee for any bounced checks.

By signing below, I understand and agree to the above statements. *I authorize my insurance benefits to be paid directly to Hope for a Better Tomorrow.*

____ ____________

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person.

____ ____________

Administrative Signature Date

HOPE FOR A BETTER TOMORROW

TREATMENT PLAN ACKNOWLEDGEMENT FORM

At Hope for a Better Tomorrow, you will participate in the development of your treatment plan. The treatment plan is your "map of care" which includes specific goals that you wish to accomplish. With your therapist, you will discuss frequency of treatment and what types of services and modalities will help you reach your goals.

Therapists at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for your signature to acknowledge that you have played an active role in the treatment planning process.

If you have further questions regarding this form, please consult with your therapist.

Client Print Name:____ Date:__________

Client Signature: ____ Date:__________
(Parent or Guardian if under 18)

Health Risk Assessment

Name____________________________Date________

Please circle the number which best identifies your response to each corresponding question-
1. Never or Almost Never; 2. Occasionally;
3. Often; 4. Very Often; or 5. Always or Almost Always

1. I engage in moderate physical activity outside of work for at least 20 to 30 minutes at least 5 days of the week.

   N/A 1 2 3 4 5

2. I enjoy physical activities rather than sedentary activities.

   N/A 1 2 3 4 5

3. I eat at least five servings of fruits and vegetables every day (one serving equals one half cup).

   N/A 1 2 3 4 5

4. I eat at fast food restaurants more than three times per week.

   N/A 1 2 3 4 5

5. I avoid the use of tobacco products (cigarettes, smokeless tobacco, cigars, and pipes).

   N/A 1 2 3 4 5

6. I limit myself to 5 drinks of alcohol a week (beer, liquor, wine).

   N/A 1 2 3 4 5

7. I see my physician for routine check-ups, health screenings, and disease prevention.

   N/A 1 2 3 4 5

8. I wear a seat belt when traveling in a vehicle.

   N/A 1 2 3 4 5

9. I take time to have meaningful interactions with family and friends.

   N/A 1 2 3 4 5

10. I contribute time and/or money to at least one organization that strives to better the community where I live.

    N/A 1 2 3 4 5

11. I am able to develop close, personal relationships with others.

    N/A 1 2 3 4 5

12. I feel that I am a confident individual.

    N/A 1 2 3 4 5

13. I express my feelings of anger and frustration in ways that are not hurtful to myself or others.

    N/A 1 2 3 4 5

14. I feel that I have family and friends that I can confide in to assist in managing stress.

    N/A 1 2 3 4 5

15. I seek opportunities to learn new things through different mediums such as television, books, newspaper, internet, etc.

    N/A 1 2 3 4 5

16. Before making decisions, I gather facts and consider all viable options.

    N/A 1 2 3 4 5

17. I am satisfied with the balance between my work time and leisure time.

    N/A 1 2 3 4 5

18. The level of stress in my work environment is manageable for me.

    N/A 1 2 3 4 5

19. I feel that my life has a purpose.

    N/A 1 2 3 4 5

20. My actions are guided by my own beliefs rather than the beliefs of others.

    N/A 1 2 3 4 5

HOPE FOR A BETTER TOMORROW

INFORMED CONSENT POLICY

It is the policy of this clinic that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive at all of our clinic locations. It is our agency's policy to offer this information in both verbal and written form. All patients will be provided, and should take, the necessary time to review this informed consent policy prior to the onset of treatment. You may also ask for additional information from your therapist regarding any particular treatment at any time during the course of treatment.

Completed and accurate information must be provided concerning each of the following areas:

1. The benefits of the proposed treatment.
2. The way in which the treatment will be administered, the treatment schedule, and my involvement in the development of my treatment plan.
3. The expected side effects from the treatment and/or risks of side effects from medications.
4. Alternative treatment modalities.
5. The probability of consequences of not receiving treatment.
6. The consequences of the continued use of alcohol or other drugs, unauthorized absences or any other evidence of noncompliance.
7. My financial obligations regarding my treatment cost.
8. Information regarding sexually transmitted diseases and communicable diseases.
9. The time period for which the informed consent is effective.
10. Your rights as a patient to withdraw the informed consent at any time in writing.
11. Hope for a Better Tomorrow provides mental health services at our facility. Mental health staff may be involved in your treatment planning and referrals may be made.
12. Client records are kept securely for mental health patients.
13. I understand that this informed consent is good for the course of treatment
14. I understand that this informed consent is to expire in 15 months.
15. I understand that I can withdraw my consent, in writing, at any time.

My signature indicates that (1) I have read and I understand the above policy and procedures pertaining to my granting of informed consent for the treatment which I choose to receive and (2) that I have been presented with the necessary and appropriate information either verbally or in writing, and that I have also had adequate time to consider this information, and that I do herby give my informed consent to participate in the recommended treatment. I have also received a copy of this document.

NAME (PRINT) DATE

SIGNATURE DATE

SIGNATURE (PARENT OR GUARDIAN) DATE

HOPE FOR A BETTER TOMORROW

PRIMARY PHYSICIAN & PSYCHIATRIST-PATIENT CARE COMMUNICATION FORM

Clinicians at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for permission to notify your primary care physician and/or psychiatrist. By signing this form, it gives your Hope for a Better Tomorrow therapist permission to contact your primary care physician and/or psychiatrist to introduce themselves as your behavioral health care practitioner and work directly with them when necessary (for example: strategies for better medication management, coordination of care and treatment recommendations).

If you have further questions regarding this form, please consult with your therapist.

Physician or Psychiatrist Name:______________________________

Address:______________________________

Phone:____________________ **Fax:**____________________

____ Yes, I want this information released to my Primary Care Physician or Psychiatrist.
____ No, I do not want this information released to my Primary Care Physician or Psychiatrist.
____ I do not have a Primary Care Physician or Psychiatrist at this time.

Authorization to Disclose Information

To the patient: Disclosure of the above information is for coordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected under federal law. Releasing this information to your physician is strictly voluntary and does require your written consent for this form to be sent, it does not allow for any other information to be disclosed nor does it allow for any form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided to you. To the party receiving the information: This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations prohibit you from making further disclosure of this information.

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year.

Print Patient Name: ______________________________

Signed:______________________________ ____________ ____________
(Client 12 years of age and older) Date Witness

Signed:______________________________ ____________ ____________
(Parent or Guardian Signature, 12 years and younger) Date Witness

OFFICE USE ONLY
Letter and Form Sent: ____________
Date & Initials