



Intake Form

The following confidential information form is for the use of the therapist only. Complete it as carefully as possible. If the form pertains primarily to a minor, the parents may need to provide most of the answers.

Demographic Information

Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile Phone: _____

Email Address: _____

DOB: _____ Age: _____ Gender: _____

Nationality or Ethnicity: _____

How did you hear about us? _____

Marital Status

___ Single ___ Married ___ (years) ___ Divorced ___ (years) ___ Living Together ___ (years)

___ Separated ___ (years) ___ Widowed ___ (years)

Emergency Contact

Name: _____ Relationship to Client: _____

Home Phone: _____ Cell Phone: _____

Employment Status

___ Employed Full-time ___ Employed Part-time ___ Unemployed ___ Other: _____

Occupation: _____ Employer: _____

Education

Highest Level of Education Completed: _____ Degree Obtained: _____

Spiritual/Religious Preference

___ Christian ___ Muslim ___ Jewish ___ Other: _____

Intake Form

Current Symptoms/Behaviors

Please mark below, the symptoms which you have experienced in the past 3 months.

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Avoiding People |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Obsessions or compulsions | <input type="checkbox"/> Problems getting along with family |
| <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Feeling Fearful |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Problems with anger |
| <input type="checkbox"/> Change in sleeping habits | <input type="checkbox"/> Trouble performing at school/work |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Feeling anxious |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Lack of enjoyment of usual activities |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Acting violently |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Feeling tearful or crying spells |
| <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Muscle tension |
| <input type="checkbox"/> Feeling of extreme happiness | <input type="checkbox"/> Sudden feelings of panic |
| <input type="checkbox"/> Self-esteem problems | <input type="checkbox"/> Physical complaints of pain |
| <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Thoughts of hurting yourself/others |
| <input type="checkbox"/> Change in sexual interest or function | |
| <input type="checkbox"/> Difficulty Concentrating | |

Please describe the issue that brought you in today:

Any history of abuse (physical, emotional, or sexual): _____

Medical Information

Primary Doctor Name: _____ Doctor Number: _____

Doctor Fax: _____

List all past/current illnesses, injuries or handicaps: _____

List any allergies: _____

List any (prescription or over-the-counter) medication that you are currently taking: _____



Intake Form

Substance Abuse History

Please list any drugs that you have taken in the past: _____

Is there a history of substance abuse in your family? _____

List history of substance abuse treatment: _____

Mental Health History

Have you ever been in therapy before? ___Yes ___No If yes, please describe below:

1) Name of therapist: _____ Dates _____

Type/effectiveness of treatment _____

2) Name of therapist _____ Dates _____

Type/effectiveness of treatment _____

Previous psychiatric hospitalizations? _____

Previous psychiatric medications? _____

Legal Issues

Any custody issues or other legal issues: _____

Treatment Information

List three goals you would like to focus on in therapy:

1. _____

2. _____

3. _____

List the three strengths about yourself:

1. _____ 2. _____ 3. _____

Clients Signature/Date: _____

Consent to Treatment

Kaleidoscope Counseling

I acknowledge that I have received, have read (or have had read to me), and understand the professional disclosure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel 24 hours before my scheduled appointment, I will be charged the full fee of my counseling session.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)	Date
Printed name	Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist	Date



Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. You will receive a copy of the updated privacy practices if changes are made.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked.. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative Date

Printed name of client or personal representative Relationship to the client

Signature of authorized representative of this office or practice

Date _____

Debit and Credit Card Payment Authorization

Kaleidoscope Counseling

I am providing my debit or credit card information below for the purpose of paying for my sessions at Kaleidoscope Counseling under the following conditions:

1. My card will be charged the full fee of my counseling session after each missed appointment that I do not cancel with 24 hours notice.
2. My card will be charged when insurance does not cover my sessions, prior to to this charge I may opt at any appointment to pay by cash or check in lieu of debit or credit card to pay for charges not covered by insurance.
3. I will receive a transaction receipt by email each time the card is successfully charged.
4. This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

Credit Card Information

Card Type:

Visa MasterCard American Express Discover

Client Name

Card Number

Back side 3 digits / Front side 4 digit (if AmEx)

Expiration

Zip Code

Email

Client Agreements:

I agree to make payments in cash, by check or debit/credit within 24 hours if a transaction with my card is ever denied.

I agree to having my card charged for missed appointments.

I agree to having my card charged for appointments I cancel with less than 24 hours notice.

Signature: _____ Date: _____