

INTAKE FORM

Angela Gurno, MS, LPC, NCC

Licensed Professional Counselor

CONFIDENTIAL

Date: _____

This form will help your counselor understand more about you and will be part of your case file.

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ Age: _____ Gender: Male Female

Ethnicity: _____

Address: _____

City _____ State _____ Zip Code _____

Client SSN# _____ Email: _____

Please provide the number that is the best to reach you:

Home Phone:	Work Phone:	Cell Phone:
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No

Occupation: _____ Employer: _____

Marital Status: _____ Prior Marriages: _____ Education: _____

Spouse Last Name: _____ Spouse First Name: _____ Spouse MI: _____

Occupation: _____ Employer: _____

Children:

Name	Sex	Age	Relationship to you

Primary Care Provider: _____ Phone Number: _____ Fax: _____

I would like for the Therapist to communicate with my Primary Care Provider regarding my Treatment: Yes or No

INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____

Insurance Telephone Number: _____ Group Number: _____

Subscriber's Name/Insured Name: _____

Insured SSN: _____ Insured Birth date: _____

Relationship to client: _____

Who referred you: Self Dr. _____ Web Insurance Other: _____

Primary Concern:

What brought you here today?

Please use the following scale to answer the next three questions:		1	2	3	4
		Not at all	Mildly	Moderately	Highly
1.	How serious do you consider your present concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	How motivated are you to resolve your concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	How optimistic are you that your concern(s) can be resolved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Counseling? Yes / No Counselor: _____ Date: _____

Please list your current medications and doses:

Prescription:	Over the Counter:
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Please list any Food or Drug Allergies or any adverse reactions you have experienced:

Please list any medical problems:

Medical Problem	Date of Diagnosis

DEVELOPMENT (If client is a child or adolescent)

Please check any if there were problems in the following areas:

<input type="checkbox"/>	During Pregnancy	<input type="checkbox"/>	After birth	<input type="checkbox"/>	Talking
<input type="checkbox"/>	During Birth	<input type="checkbox"/>	Walking	<input type="checkbox"/>	Sitting up
<input type="checkbox"/>	Other	<input type="checkbox"/>		<input type="checkbox"/>	

If yes, please explain: _____

FAMILY and MEDICAL TREATMENT HISTORY

Please check any medical and /or mental health conditions that apply to any family members:

<input type="checkbox"/>	Heart Disease/Condition	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Use or Abuse Alcohol or Drugs	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Other Medical Conditions:	<input type="checkbox"/>	Other Mental Health Conditions:

Family History Continued	Mother's Age _____ If deceased, how old were you when she died? _____
	Father's Age _____ If deceased, how old were you when he died? _____
	If your parents are separated, how old were you then? _____
	Number of brother(s) _____ What are their ages? _____
	Number of sister(s) _____ What are their ages? _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality: Briefly describe your father's personality:	Briefly describe your stepparent(s) personality:
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Briefly describe your past and current relationships with your:

Mother Stepmother	Father Stepfather
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Religious Affiliation	<input type="checkbox"/> Jewish	<input type="checkbox"/> Christian/Other _____
	<input type="checkbox"/> Catholic	<input type="checkbox"/> None, but I believe in God
	<input type="checkbox"/> Protestant _____	<input type="checkbox"/> Atheist or agnostic
	Do you desire to have your religious beliefs and values incorporated into the counseling process? (Please check one)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		

Please mark all of the following that apply

Feelings		Thoughts	
<input type="checkbox"/> Helpless	<input type="checkbox"/> Anxious/Fearful	<input type="checkbox"/> Confused	<input type="checkbox"/> Racing
<input type="checkbox"/> Depressed/Sad	<input type="checkbox"/> Out of Control	<input type="checkbox"/> Fragmented	<input type="checkbox"/> Obsessive
<input type="checkbox"/> Shameful	<input type="checkbox"/> Afraid/Scared	<input type="checkbox"/> Worthless	<input type="checkbox"/> Distracted
<input type="checkbox"/> Angry	<input type="checkbox"/> Burnt out/worn out	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Intrusive Memories
<input type="checkbox"/> Guilty/Remorseful	<input type="checkbox"/> Relaxed	<input type="checkbox"/> Unattractive	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Hopeless/Hopeful	<input type="checkbox"/> Happy/Excited	<input type="checkbox"/> Unlovable	<input type="checkbox"/> Worry
<input type="checkbox"/> Lonely	<input type="checkbox"/> Irritable	<input type="checkbox"/> Confident	<input type="checkbox"/> Sensitive
<input type="checkbox"/> Grieved	<input type="checkbox"/> Empty/ Numb	<input type="checkbox"/> Worthwhile	<input type="checkbox"/> Distrust
<input type="checkbox"/> Stressed	<input type="checkbox"/> Insecure	<input type="checkbox"/> Suicidal/Homicidal	<input type="checkbox"/> Positive
<input type="checkbox"/> Unhappy/Unfulfilled	<input type="checkbox"/> Mood Swings		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

Symptoms/Behaviors		
<input type="checkbox"/> Eating More or Less	<input type="checkbox"/> Acting Out Sexually	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Procrastinating	<input type="checkbox"/> Acting Aggressively	<input type="checkbox"/> Legal Problems
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Phobia/Panic Attacks	<input type="checkbox"/> Parent/Child Conflicts
<input type="checkbox"/> Irritability	<input type="checkbox"/> Post Traumatic Stress Disorder	<input type="checkbox"/> Marital Problems
<input type="checkbox"/> Crying	<input type="checkbox"/> Attention Deficit Disorder/ADHD	<input type="checkbox"/> Relationship Concerns
<input type="checkbox"/> Passivity	<input type="checkbox"/> Injuring self	<input type="checkbox"/> Withdrawal from Family/Friends
<input type="checkbox"/> Acting Compulsively	<input type="checkbox"/> Sexual Concerns	<input type="checkbox"/> Job Problems
<input type="checkbox"/> Poor Self-Image	<input type="checkbox"/> Legal/Illegal Drug Use	<input type="checkbox"/> Spiritual Issues
<input type="checkbox"/> Poor Concentration/Memory	<input type="checkbox"/> Alcohol Use/Abuse	<input type="checkbox"/> Victim or Perpetrator of Abuse
	<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Seeing/Hearing things others don't
	<input type="checkbox"/> Other Addictions	<input type="checkbox"/> Other _____
Physical Symptoms		
<input type="checkbox"/> Insomnia	Will you be sharing any important Cultural values that might impact your therapy process: Yes___ No___	
<input type="checkbox"/> Tired/ Easily Fatigued		
<input type="checkbox"/> Restlessness/Tense		
<input type="checkbox"/> Rapid Speech		
<input type="checkbox"/> Headaches		
<input type="checkbox"/> Tightness In Chest		
<input type="checkbox"/> Dizziness or Light-headedness		
<input type="checkbox"/> Numbness or Tingling	Please share anything else that might be helpful for your counselor to know:	
<input type="checkbox"/> Pain		
<input type="checkbox"/> Rapid Heart Beat		
<input type="checkbox"/> Weight Gain or Loss		
<input type="checkbox"/> Excessive Sleep		
<input type="checkbox"/> Loss of Memory		
<input type="checkbox"/> Eating Problems		
<input type="checkbox"/> Other _____		

I authorize Angela Gurno to use my health information to activate my insurance benefit program. The purpose will be to process claims for insurance payment. I also understand my privacy will be respected and procedures will follow the HIPAA Privacy Notice that I have received.

Client Signature

Date

Parent/Guardian Signature (if client is under 18)

Date

Angela Gurno, MS, LPC, NCC

Licensed Professional Counselor OUTPATIENT SERVICES CONTRACT

COUNSELING SERVICES

Welcome to my practice. This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you have so they can be discussed. When you sign this document, it will represent an agreement between us.

Counseling is not easily described in general statements but depends on the counselor, client and the particular problems presented. Counseling calls for an interaction between therapist and client and for therapy to be successful, clients are to employ concepts, strategies and techniques discussed during sessions. Therapy can have some unpleasant aspects that may be coupled with uncomfortable feelings. However, these experiences often lead to improved relationships, solutions to problems, and a reduction in feelings of distress.

COUNSELING SESSIONS

Issues and concerns are evaluated during the first session and continue throughout the therapeutic process. During this time, it can be determined if the client/therapist relationship will be able to generate the desired treatment goals. Counseling sessions are 50 minutes and begin on a weekly or bi-weekly schedule and are then scheduled less frequently based on progress. The client is responsible for scheduling their sessions and canceling them if they are unable to attend. We request a twenty-four hours notice or a \$25.00 fee will be assessed for the missed session. This fee cannot be billed to your insurance and must be paid out of pocket at the next session. The office answering machine is on 24 hours a day for your convenience.

PROFESSIONAL FEES AND BILLING SERVICES

The hourly fee for therapy is \$65.00. Payment is expected from the client at the time of service or from the insurance company. Insurance is to be activated before scheduled therapy. The billing person works with the client concerning pre-certification and explanation of benefits. Other professional services such as preparation of documents or treatment summaries will be billed at the same rate as counseling.

PLEASE NOTE: The therapist does not participate in legal proceedings but will refer the client to another clinician or entity that deals with legal issues. Please discuss this with the therapist if the need arises.

CONTACTING ME

The office telephone is answered by support staff from 8:30 AM and 7 PM, Monday thru Thursday and partially on Fridays; however, voicemail is available 24 hours a day. The therapist is usually in session and not available by telephone. Please leave a message with the support staff or on the voice mail. Every effort will be made to return all calls as soon as possible. In case of an urgent need or emergency on weekends, the client may use the therapist's home telephone number that is located on their business card. If the client cannot reach the therapist and can't wait for a return call, they are encouraged to call 911 or go the nearest emergency room.

PROFESSIONAL RECORDS

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client's consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client's request.

MINORS

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will provide more specific information as approved by the adolescent client. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.

PLEASE NOTE: The therapist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

CONFIDENTIALITY

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client’s written permission. However, there are exceptions:

- The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.
- The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
- The therapist is legally obligated to release the client’s therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist

FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Any email the therapist receives from the client and any responses sent, will be printed out and kept in the client’s treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

Client Signature

Date

Client Printed Name

Date

If client is under 18, parent/guardian consent is needed.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Date

Witness

Date