INITIAL COMPLAINTS & IN-TAKE

Client Name:_____

FAMILY HISTORY

Client Name:_____ Children ◯ Yes ◯ No How Many:____
Address:_____ Child1: _____
City, State, Zip:_____ DOB1: _____
Home Phone:_____ Child2: _____
Resident How Long: _____ DOB2:_____
Date of Birth:_____ Child3: _____
Birth Place:_____ DOB3:_____
Delivery Method:_____ Child4: _____
Delivery Complications_____ DOB4:_____
Resident How Long: _____ Child5:_____
DOB5: _____

Father: _____
Deceased ◯ Yes or ◯ No Date:_____
Relational History ◯ Good ◯ Average ◯ Poor
Comment_____

Mother:_____
Deceased ◯ Yes or ◯ No Date:_____
Relational History ◯ Good ◯ Average ◯ Poor
Comment_____

Siblings: ◯ Yes or ◯ No

How many **brothers:** ____

Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____

*DOD = Date of Death

How many **sisters:** ____

Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____
Name: _____	DOB:_____	DOD:_____

*DOD = Date of Death

Significant Sibling Relational History
Comment (Name of Sibling & Events)_____

Marital / Relationship Status
☐ Single Always: ◯ Yes or ◯ No
☐ Significant Other Date:_____

Sig. Other Name: _____
Relational History ◯ Good ◯ Average ◯ Poor
Comment_____

☐ Significant Other-2 Date:_____

Sig. Other Name: _____
Relational History ◯ Good ◯ Average ◯ Poor
Comment_____

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☐ Significant Other-3	Date:_____	Sig. Other Name: _____ Relational History ◯ Good ◯ Average ◯ Poor Comment_____
☐ Married ☐ Separated ☐ Divorced	Date:_____ Date:_____ Date:_____	Spouse Name: _____ Relational History ◯ Good ◯ Average ◯ Poor Comment_____
☐ Married-2 ☐ Separated-2 ☐ Divorced-2	Date: _____ Date: _____ Date: _____	Spouse Name: _____ Relational History ◯ Good ◯ Average ◯ Poor Comment_____
☐ Married-3 ☐ Separated-3 ☐ Divorced-3	Date: _____ Date: _____ Date: _____	Spouse Name: _____ Relational History ◯ Good ◯ Average ◯ Poor Comment_____

COUNSELING HISTORY:

_____ Mark "X" if Never in Counseling Last Time in Counseling: _____How long:_____
Purpose of prior counseling:_____

Provider Name:_____ Title:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
(If contact is made with providers a Release of Information (ROI) must be signed for LaRose to initiate a request for records).

MEDICATION & MENTAL HEALTH DIAGNOSTIC HISTORY:

Psychiatric Hospitalizations

Date1:_____	Hospital 1 Name:_____
City: _____State:____Zip:_____	How long there_____
Date2:_____	Hospital 2Name:_____
City: _____State:____Zip:_____	How long there_____
Date3:_____	Hospital 3 Name:_____
City: _____State:____Zip:_____	How long there_____

(If contact is made with providers a Release of Information (ROI) must be signed for LaRose to initiate a request for records).

Diagnoses Previously Made

Attention Deficit Disorders (specify): _____
Learning Disorders (specify): _____
Mood Disorders (specify):_____
Substance Related Disorders (specify):_____
Cognitive Disorders (specify):_____
Psychotic Disorders (specify):_____
Anxiety Disorders (specify):_____
Sleep/Eating Disorders (specify):_____
Personality Disorders (specify):_____
Other (specify):_____

Diagnosing1 Provider Name: _____

Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
(If contact is made with providers a Release of Information (ROI) must be signed for LaRose to initiate a request for records).

Diagnosing2 Provider Name: _____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
(If contact is made with providers a Release of Information (ROI) must be signed for LaRose to initiate a request for records).

Current or Past Medications

Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N
Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N
Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N
Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N
Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N
Name:_____ _____mg Dose: _____ Start Date___/___/___ Current: Y or N

Chemical use / Dependency:

Drug of Choice _____ Started when _____
Using Now ◯ Yes or ◯ No How Much_____
Other Use ◯ Yes or ◯ No
What Drug _____ How Much_____
Other Drug _____ How Much_____

Diagnosing Provider Name: _____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____

Consider self an addict ◯ Yes or ◯ No Since when_____
Father diagnosed alcoholic / addict ◯ Yes or ◯ No Mother diagnosed alcoholic / addict ◯ Yes or ◯ No
Sibling 1 diagnosed alcoholic / addict ◯ Yes or ◯ No Name_____
Sibling 2 diagnosed alcoholic / addict ◯ Yes or ◯ No Name_____

History of alcohol/drug problems or concerns related to alcohol/drug use ◯ Yes or ◯ No

Work/ School ◯ Yes or ◯ No Specify Problem(s) _____
Legal ◯ Yes or ◯ No Specify Problem(s) _____
Finance ◯ Yes or ◯ No Specify Problem(s) _____
Partner/Kids ◯ Yes or ◯ No Specify Problem(s) _____
Self ◯ Yes or ◯ No Specify Problem(s) _____
Sexual ◯ Yes or ◯ No Specify Problem(s) _____
Health ◯ Yes or ◯ No Specify Problem(s) _____
Over Dose ◯ Yes or ◯ No Specify Problem(s) _____
Suicide ◯ Yes or ◯ No Specify Problem(s) _____

Rehab ◯ Yes or ◯ No Date: _____ Clean/Sober Date: _____
12 Step Model ◯ Yes or ◯ No Meetings ◯ Yes or ◯ No Sponsor: ◯ Yes or ◯ No
Other Recovery Method: _____

PHYSICAL / BIOLOGICAL CONSIDERATIONS

Currently under the care of a physician/ARNP: ◯ Yes or ◯ No
The last time seen by a medical provider was:_____
The last time you had a complete physical exam was: _____ Doctor: _____
Current Doctor's/ARNP's name:_____Phone:_____City:_____

You would say that your physical health is:
◯ Poor ◯ Fair ◯ Good ◯ Excellent
Physical problems you have (or believe you have):

1._____ Dx: _____ Since:_____
2._____ Dx: _____ Since:_____
3._____ Dx: _____ Since:_____
4._____ Dx: _____ Since:_____
5._____ Dx: _____ Since:_____
6._____ Dx: _____ Since:_____

* DX = If Diagnosed by a doctor – what is the diagnosis given?

If you were asked to see a doctor to get a complete physical exam, would you agree to do so, and provide records to LaRose, if requested? ◯ Yes or ◯ No

COMPLAINTS, PATTERNS & OTHER OBSERVATIONS

Sleep ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent
Number of Hours_____
Comment _____

Energy ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent
Sleep often? _____
Comment _____

Appetite ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent
Number of Meals Daily_____
Comment _____

Mood ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent
Crying Spells? _____
Comment _____

Anhedonia ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent
Joy / Pleasure? _____
Comment _____

Concentration ◯ Poor ◯ Fair ◯ Average ◯ Good ◯ Excellent

Easily Distracted /Off Task? _____
Comment _____
_____
_____

Memory ○ Poor ○ Fair ○ Average ○ Good ○ Excellent
Forgetful? _____
Comment _____
_____
_____

Motivation ○ Poor ○ Fair ○ Average ○ Good ○ Excellent
Goals? _____
Comment _____
_____
_____

Irritability ○ Poor ○ Fair ○ Average ○ Good ○ Excellent
Anger Outbursts? _____
Comment _____
_____
_____

Anxiety ○ Poor ○ Fair ○ Average ○ Good ○ Excellent
Heart Palpitations / Afraid to go out? _____
Comment _____
_____
_____

Libido ○ Poor ○ Fair ○ Average ○ Good ○ Excellent
Are you attracted / desire sex? _____
Comment _____
_____
_____

COURT ORDER / MANDATED THERAPY AND ASSESSMENT

If I have been court ordered or legally mandated to seek and obtain mental health counseling services, either for assessment or treatment - or both, I hereby authorize LaRose to communicate with the appropriate legal representative who monitors compliance - at will - until such time as the legal mandate is satisfied or withdrawn, according to the dictates of the appropriate governing authority. Because of the nature of a court order and/or a legal mandate, I acknowledge that LaRose will release any/all information as legally required to meet the legal mandate, which necessitates my treatment. The name of the person who oversees my case is:

Contact Name: _____
Contact Title: _____
Agency Name: _____
Agency Address: _____
City, State, Zip: _____
Phone: _____
Email: _____

THIRD PARTY, EAP, PROVIDER NETWORK, PAYOR AGREEMENT & RECORDS RELEASE

This section ◯ is applicable or ◯ is not applicable to the named client.

I understand that if I am requesting services that are to be billed to someone other than myself (a third party payor) LaRose will release the required / requested information to the third party payor, sufficient to obtain payment. "Sufficient to obtain payment" is, usually, defined and determined by the third party payor and could include a summary of my sessions, a diagnosis of a disorder, and the dates of service. LaRose may also release information to a third party payor related to drug/alcohol disorders, if such a disorder is determined as the primary reason for assessment, treatment, and/or intervention. The third party payor may request copies of a photo ID, a social security card, an insurance card – and a third party payor may request additional information about me, even after payment has been made. I understand that LaRose will NOT release his specific notes taken during the session without my specific written permission to do so; these kinds of notes (sometimes referred to as content/process notes) are not necessary for payment reasons, even if the third party payor should request them. This release includes telephone, fax, email, and/or traditional mail communications, for the purposes of third party payment, is granted for the named third party payor::

PAYOR NAME: _____
PAYOR ADDRESS:_____
PAYOR CITY, STATE, ZIP:_____
PAYOR PHONE:_____
PAYOR EMAIL:_____
PAYOR FAX: _____

FEE FOR SERVICE, LATE ARRIVALS and CANCELLATIONS

I understand that the counseling services that I receive while working with LaRose are being provided for a fee. The fee for services has been negotiated between LaRose and I at a rate of $_____per clinical hour (for each 50 – 55 minute session). The fee is due at the end of every session unless there is a third party payor records release signed (above). I agree to call LaRose 24 hours prior to a scheduled appointment, if I need to cancel or re-schedule. "24 hours" is based upon business days of the week. For example, to cancel a Monday appointment "24 hour notice" means that the appointment would be cancelled by the previous business day - on Friday. In this example, if it is cancelled on Saturday or Sunday the "no show fee" would be assessed and due.

In the event of an emergency or some other extreme circumstance LaRose may (or may not), at his sole discretion, waive the no show fee. I agree that if a 24-hour notice is not given and if a no show fee is charged it is immediately due. The no show fee is equivalent to the agreed to negotiated fee for services. LaRose agrees to reciprocate the 24 hour cancellation agreement. Counseling sessions last for one clinical hour (50-55 minutes). They begin and end on time. I understand that if I arrive late to an appointment, and if LaRose is still able to see me (or my child), the session will likely end at the regularly scheduled time, due to other appointments and/or scheduling demands. I understand that full payment for the session is expected even if I am late to an appointment, and even if the appointment does not last a full clinical hour, and I agree to pay the full hourly rate.

I UNDERSTAND THAT NO SHOW / NON 24 HOUR CANCELLATIONS ARE NOT COVERED BY THIRD PARTY PAYORS – AND I UNDERSTAND THAT IF A NO SHOW OR NON 24 HOUR CANCELLATION OCCURS I MUST PAY LAROSE THIS FEE BEFORE TREATMENT CAN PROCEED. I UNDERSTAND THAT LAROSE MAY BILL THESE CHARGES TO THE MAILING ADDRESS LISTED ABOVE, UNTIL SUCH TIME AS PAYMENT IS MADE.

PRACTICE INFORMATION, NON-IDENTIFYING CLINICAL CONSULTATION AND/OR EXTERNAL REFERRALS

Kurt LaRose, MSW, LCSW has provided me with the website URL (http://www.TalkifUwant.com) related to his private practice and other experience related to clinical social work and mental health services. I acknowledge that I have reviewed and signed this intake form expressing my desire to work LaRose for the purposes of counseling. If I am the legal guardian of the named "client" I am providing my consent for counseling as the legal guardian by signing below. I understand that the details of my case may be discussed with another clinician, without using my name or other identifying information, so that details related to my care can be addressed by LaRose (if necessary) and LaRose can obtain consultation in providing counseling services. I understand that LaRose must have a written release of information (ROI) to specifically

use my name and/or to identify me to another clinician. If at any time, LaRose believes that he cannot adequately provide my treatment, I understand that he may ask me to be seen by a different mental health professional. If I am referred to other professionals for services, at the recommendation of LaRose, I understand that I must make payment arrangements with them because they are not necessarily affiliated with LaRose's private practice.

ACKNOWLEDGEMENT & AGREEMENT

I have completed and read this "Initial Complaints & In-Take" form entirely, including the two paragraphs above. By signing this form, I understand that I am stating that I have given the information voluntarily or as ordered by another authority, and I hereby request counseling services from LaRose. I also understand that I may terminate counseling services at any time, and/or that LaRose may do likewise, as noted below in the section titled "voluntary decisions for treatment to end." If I, or LaRose decide to discontinue services, we may (either LaRose or I) decide to terminate sessions at any time during the course of counseling services.

ONLINE ACCESS: By entering the words "I agree" I am stating that I have read and agree to all statements related to confidentiality, online security, privacy, and the use of public/private computers with saving, downloading and completing forms from the web, as read and reviewed at the URL: http://www.TalkifUwant.com/forms.htm: _____ (type or write the words "I agree")

_____ _____

Client Signature Date Signed

_____ _____

Printed Name Relationship (if not signed by client)

_____ _____

Kurt LaRose, MSW LCSW Signature Date Signed

_____

Printed Name

_____ _____

Witness Signature Date Signed

_____ _____

Printed Name Title

FILE NOTE:

A full assessment & treatment plan is indicated for this client? ___○___ YES or ___○___ NO

THIRD PARTY PAYOR AUTHORIZATION NUMBER: _____

THIRD PARTY SESSION LIMIATION: _____

VOLUNTARY DECISIONS FOR TREATMENT TO END

CLIENT DECISION TO TERMINATE

I _____(client name) have decided that I do not want to receive counseling services at this time. My decision to decline counseling services does not affect my ability to return to LaRose in the future for treatment consideration, provided availability is not limited.

➔ _____ ← _____

Signature here, indicates your desire to discontinue counseling services at this time Date

LAROSE DECISION TO TERMINATE

I, Kurt LaRose, MSW have decided to end counseling services with _____ (client name) at this time. The date of termination is effective _____(enter date). The reason I am ending the provision of these services is:

- ○ The treatment plan has been completed.
- ○ The client requested the services to end.
- ○ A referral to a different mental health professional is indicated.
- ○ Specify reason for referral: _____

_____

_____

_____

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