3102 Golansky Blvd Ste 202
Woodbridge, VA 22192
http://www.holisticcounselinginc.org
Phone: 703.239.3268
Fax: 571.589.0132

Adult Client Intake Packet

Name: _____ DOB: _____ Date of first appt: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible.

All information provided is confidential.

Referred by:
__Medical Provider: _____
__Insurance Provider: _____
__Psychology Today
__Friend/Family: _____
__Other: _____

Have you previously received any type of mental health services? __Yes __No
If yes, which of the following?:
__Psychotherapy __Medication __Outpatient __Hospitalizations
If yes, please provide:
Name of provider or facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today?

When did the problem first start? Within the last: __30 days __6--12 months __2 years __During adolescence __During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression? __Yes __No
If yes, for approximately how long? _____
***Any Suicidal Thoughts?**__ Current? __Past? - How long ago?_____
Notes:_____
_____
_____
_____

Are you currently experiencing anxiety, panic attacks or have any phobias? __Yes __No
If yes, when did you begin experiencing this? _____

***Any history of self-harm?** __Current? __Past? – How long ago?_____
Notes:_____

***Any thoughts about harming others?** __Current? __Past? – How long ago? _____
Notes:_____
_____
_____
_____

Please describe any major losses or traumas you have experienced:

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

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

Family History

Where were you born? _____
Where did you grow up? _____ __City __Suburbs __Country

Please list your **parents** and **siblings**. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____
Mother's occupation: _____
Father's occupation? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please Circle	List Family Member
Alcohol/ Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	

Domestic Violence	Yes / No	
Sexual Abuse	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Disorder	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	
Other diagnosed mental health condition?	Yes / No: Which was?:	

Marital Status:
__Never Married __Domestic Partner __Married **If married, how long have you been married for and
what is your partners name: _____
**On a scale of 1-10 (best), how would you rate your relationship? _____
__Separated __Divorced -- For how long? _____
__Widowed: Please provide your partners name and year deceased:
_____

Are you currently in a romantic relationship?
__Yes -- How long? _____ On a scale of 1-10 (best), how would you rate your relationship? _____
__No

What is your Gender?_____ Preferred pronoun(s)?_____
What is your Sexual Orientation?_____
Any issues related to gender or sexual orientation that might be relevant to treatment?

Please list any children, their names, and ages:

Name	**Age**	**Relationship**	**Name of other parent**	**If deceased, age and cause of death**

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/ Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider(s) and contact information:
Name: _____
Specialty: _____
Facility: _____
Phone, email, or Fax: _____

How would you rate your current physical health?
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

Please list any specific and significant health problems you are currently experiencing:

How would you rate your current sleeping habits?
__Poor __Unsatisfactory __Satisfactory __Good __Very Good

If you are having problems, in which phase of sleep are you experiencing issues?
__Falling asleep __Staying asleep __Awakening early __Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____ What types of exercise do you participate in?:

Are you currently experiencing any chronic pain? __No __Yes If yes, please describe:

Substance Use

Please describe <u>current</u> use of alcohol, cigarettes, and/or recreational drugs:

Please describe <u>previous</u> use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

Occupation:_____

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your weaknesses?

What do you consider to be some of your strengths?

Reviewed by (Therapist): _____ _____ _____

Print Signed Date

See biopsychosocial assessment for additional notes

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Patient Acknowledgement
Receipt of Patient Agreement

Please sign, print your name, and date this acknowledgement form.

By signing below, I hereby acknowledge that I have been provided with the *Holistic Counseling Inc* ***Patient Agreement***. The *Patient Agreement* is available at any time in my office or by email.

I may also obtain a copy from my therapist upon request, or by Holistic Counseling Inc, or may access a copy for review in the Holistic Counseling waiting room. The Patient Agreement includes explanations of the following:

Consent for Treatment
Notice of Privacy Practices
Financial Policy
General Office Policies

"I (Guardian, if patient is a minor)_____have read in full, have been provided adequate opportunity to clarify any questions, understand, and agree to the Holistic Counseling Inc **Patient Agreement**. I also understand that the Patient Agreement may be modified without notice. I will discuss these policies with my (or the child's) therapist, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services."

Patient/ (or guardian if minor) Signature:
_____

Patient Name: _____ Guardian (if minor) Name:
_____

Witness Signature:_____ Date: _____Patient DOB:_____

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RELEASE OF MEDICAL INFORMATION

Date of Release_____

Dear Dr._____(Primary Care Physician),

We are currently working with your patient, _____, in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client's latest physical health information.

Our mailing address is: Holistic Counseling Inc

Our fax number is: 703.239.3268

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

_____ _____

Signature of Client/Guardian Date

_____ _____

Signature of Staff Witnessing Date

Date Sent to PCP: _____

Clinician: Please complete this form and either fax or mail a copy of this form to the above-mentioned doctor. Scan this completed form with the date sent in the client's chart.

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GENERAL RELEASE OF INFORMATION

CLIENT NAME: _____ DOB _____ Date of Release: _____

I hereby give my written permission for Holistic Counseling Inc to exchange the following verbal or written information as indicated with: _____ (Name or Entity).

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

__ Discharge Summary __ History & Physical __ Psychiatric Evaluation __ Progress notes
__ Medical Records __ Lab Work __ Consultations __ Treatment Plan
__ School Records __ Psychological Evaluation __ Case Coordination __ Medication Management
__ Diagnostic Information __ Treatment Recommendation

Other:_____

Date and/or condition when release will expire: _____

If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

*As the person signing this authorization, I understand that I am giving my permission to the above-named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and

that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (parent signature if client is a minor) _____ Date:_____

Staff Witnessing Signature_____ Date:_____

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CONFIDENTIAL

CREDIT CARD INFORMATION FORM

___ Please use this card for a ONE-TIME payment only

___ Please put this card on file for copayments / Co-Insurance payments

Name of client:_____

Name of card holder (as it appears on card):_____

VISA__ MASTERCARD__ DISCOVER__ AMEX__ (HSA cards are fine)

Credit Card #_____ Exp Date:_____ CCV:_____

Zip code associated with this card (billing zip):_____

I, _____, authorize *Holistic Counseling Inc* to charge this card for:

__ copayment(s)/ co-insurance(s) due, or

__for a one-time payment in the amount of: $_____

Signature:_____ Date:_____