Kara Juszczak, LCSW, PLLC

Tree of Hope Counseling, PLLC

Intake Data Form

Client info:

______________________ ________________ **DOB**:____/____/_____ **SSN**: _____-______-________
Last Name **First Name**

____
Street Address **City** **State** **Zip code**

Home Phone( )_____-_______ Work Phone( )______-_______ Alternative/Cell Phone( )_____-_______

Emergency Contact____________________________ Phone( )______-_______ Relationship_______________

Currently Employed or in School: [ ] Yes [ ] No If yes;

Employer/School ________________________________ Position/Title/Grade__________________________

Highest Education level/Degree obtained: High School Grade______ College Masters/Doctorate

Health Insurance ___________________________ Contract #___________________________________

Phone Number listed on Back of Ins Card: ____

Subscriber Name: _______________________________ Subscriber - DOB_____/______/________

Address (if different) ____

Secondary Insurance: [ ] Yes [ ] No, If Yes____

Religious Affiliation:_________________________________ Practicing/Non-practicing None

<u>Medical History</u>

Physician_____________________________________ Phone number( )______-_______

____
Street Address **City** **State** **Zip code**

Date of last Physical: ___________________

Date of last visit _____/_____/______ Purpose: ____

Currently receiving treatment for any medical condition(s)? [ ] Yes [ ] No If yes, Describe:

Any known allergies [ ] Yes [ ] No If yes, Describe:

Medications	Prescribed by	Date started	Dose	Purpose

Have you ever been hospitalized? [ ] Yes [ ] No If yes, Describe:

Social History

Current living situation: [ ] Living alone [ ] w/spouse/partner [ ] w/family/relative [ ] w/non-related persons [ ] other ________________________________

Client's primary relationship status: [ ] Single [ ] Married [ ] Living Together (as Married) [ ] Widowed [ ] Separated [ ] Divorced [ ] Child in Common

Current Spouse/Partner Information:

Name:____ Age: _____ Together [ ] Living Apart [ ]

Please list all your children/dependents and/or other household members:

Name	Relationship	Age	DOB	Living in residence
				Y/N______
				Y/N______
				Y/N______
				Y/N______
				Y/N______
				Y/N______

Father's name________________________ Age______ Mother's name______________________ Age_____

Siblings	Age	Siblings	Age

Any past or current events, losses or other family related issues that could be helpful

Counseling:

What is your reason for seeking counseling/evaluation at this time?

____

____

____

What are your goals for counseling? ____

____

____

____

Have you been in counseling before? [ ] YES [ ]NO

Counselor	Reason	When	Helpful
			Y/N
			Y/N

Have you ever been psychiatrically hospitalized, previously diagnosed or treated for a mental health condition?

Yes [ ] No [ ] If Yes, Explain____

____

____

When I am stressed, I ________. (circle all that apply).

Sleep too much	Cannot Sleep	Eat	Lose appetite	Talk it out	Isolate
Argue/fight	Watch TV	Read	Smoke	Use Drugs	Have a drink(s)
Shop	Gamble	Have sex	Lose interest(s)	Do a hobby	Feel depressed
Feel Anxious	Exercise	Cry	Listen to music	Focus on work	Tackle Chores
Cannot relax	Worry	Feel Angry	Feel Overwhelmed	Self-mutilate	Take Risks

Think about Suicide   Plan Suicide   Think about hurting someone else   Plan to hurt someone else

Other____

Support System

Who can you count on for support?

Parents Spouse Siblings Employer Church/Pastor

Therapist Neighbor Extended Family Close Friend

Self-help Group Community Services Co-Worker Medical Doctor

Other____

Please describe anything else you think would be helpful for me to know about you:

By signing below, I acknowledge the information provided is accurate and true to the best of my ability,

______________________________	____________	____________________________
Client Signature	Date	Client Printed name
______________________________	____________	____________________________
Legal Guardian/Parent	Date	Relationship

Intake Notes (office use):

Clinician: ______________________________ Date Completed: _________________

Tree of Hope Counseling, PLLC

Counseling Agreement

Read and Initial below:

_____ I understand that participation in counseling is a voluntary decision

_____ I understand that all information is confidential except:

-If there is a signed consent to release information for case management, payment, referral or operational procedures

-In the event of threat or action to harm self

-In the event of threat or action to cause harm to others

-In the event of danger, maltreatment or neglect of a child

-In the event of a court order requesting PHI/medical records

_____ I understand the 24-hour cancellation policy and if I cancel with less than 24 hours or do not show up for a scheduled session, my EAP provider will only provide payment for one visit. On my second cancellation or no show, I will be responsible for the session fee of $60.

_____ I attest that all the information I have provided is truthful to the best of my knowledge.

______________________________	_____/_______/______	______________________________
Client Signature	Date	Printed name
______________________________	_____/_______/______	______________________________
Legal Guardian/Parent	Date	Relationship
______________________________	_____/_______/______	
Witness	Date	

Tree Of Hope Counseling, PLLC
Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:___________________________________

DOB: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Tree of Hope Counseling, PLLC's ~ Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can submit a question, concern or complaint in writing to Peter Navratil (Administrator) or the Secretary of the Department of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257 Toll Free: 1-877-696-6775

____ ________________
Signature of Patient/Client **Date**

____ ________________
Signature or Parent, Guardian or Personal Representative * **Date**

____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____
Clinician **Date**

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