Kara Juszczak, LCSW, PLLC
95 Allens Creek Road, Building 1, Suite 110, Rochester, 14618 * 585.880.8838

Intake Data Form

_____ _____ DOB:____/____/_____
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

Medical History:

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 [ ] 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	Chores	Listen to music	Focus on work	Cry
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 (16+)	Date	Client Printed name
_____	_____	_____
Legal Guardian/Parent	Date	Relationship

_____

Intake Notes (office use):

Clinician: _____ Date Completed: _____

Kara Juszczak, LCSW,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 that any outstanding costs/balance(s) are my responsibility, including,
-I understand I need to provide information/insurance updates in a timely manner
-I agree to the release of PHI, if I have an unpaid balance, for the purpose of collections
-I understand any service fees not reimbursed by a third-party are my responsibility

_____ I understand there is a fee for any insufficient fund/denied payment charges of $45.00

_____ I understand payment of co-pays/fees are due at the time service is rendered, unless previously arranged

_____ I understand the 24-hour cancellation policy and the cancellation/no-show fee is my responsibility if I cancel with less than 24 hours or do not show up for a scheduled session ($95 for private pay patients and $50 for patients for whom I am billing insurance for kept sessions)

_____ I understand the fees for counseling services, unless otherwise stated, are:
Session Fee $95

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

_____	_____/_____/_____	_____
Client Signature (16+)	Date	Printed name
_____	_____/_____/_____	_____
Legal Guardian/Parent	Date	Relationship
_____	_____/_____/_____	
Kara Juszczak, LCSW	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 Signature Date