



Adult Intake Forms

How Did You Hear About Indigo Counseling Center? _____

Client's Legal Name _____ Date ____/____/____

Preferred Name _____ Gender _____

Pronouns (i.e. she/her, he/him, they/them) _____ Sexual Orientation _____

Cultural/Ethnic/Racial Identity _____

Religious/Spiritual Beliefs _____

Date of Birth ____/____/____ Age _____ Email Address _____

Phone (cell) _____ (text) _____ (other) _____

Okay to contact via phone? _____ text? _____ email? _____

Address _____ City: _____ State _____ Zip _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Address _____ Email: _____

Primary Reason(s) for Seeking Services:

Abuse Issues ____ Addictive Behaviors ____ Alcohol/Drugs ____ Anger Management ____

Anxiety ____ Coping ____ Depression ____ Eating Disorder ____ Fears/Phobias ____

Gender Issues ____ Grief ____ Mental Confusion ____ Relationship Struggles ____ Sexuality/

Sexual Identity Concerns ____ Sleeping Problems ____

Other Mental Health Concerns (Please specify): _____

Marital Status:

Single ____ Committed Relationship ____ Married ____ Divorced ____ Separated ____

Divorce in Progress ____ Widowed ____ Unmarried, Living Together ____ Polyamorous ____

Quality of Relationship: Great ____ Good ____ Fair ____ Poor ____

Family Information:

Relationship	Name	Age	Living	Living with you
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Significant Others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with you
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parental Information

Parents Legally Married
 Parents Have Ever Been Separated
 Parents Ever Divorced

Mother Remarried: Number of Times: _____
 Father Remarried: Number of Times: _____

Counseling/Prior Treatment History:

Information about CLIENT (past and present):

	Yes	No	When	Where	Your reaction to experience
Counseling	_____	_____	_____	_____	_____
Psychiatric Treatment	_____	_____	_____	_____	_____
Suicidal Thoughts/Attempts	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Self-Help Groups (i.e. AA, Al Anon)	_____	_____	_____	_____	_____

Information about FAMILY/SIGNIFICANT OTHERS (past and present):

	Yes	No	When	Where	Your reaction to experience
Counseling	_____	_____	_____	_____	_____
Psychiatric Treatment	_____	_____	_____	_____	_____
Suicidal Thoughts/Attempts	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Self-Help Groups (i.e. AA, Al Anon)	_____	_____	_____	_____	_____

Development:

Childhood/Teen

Are there any special, unusual, or traumatic circumstances that affected your development?

Yes No

If yes, please describe: _____

Has there been a history of child abuse? ____ Yes ____ No

If yes, which type? ____ Sexual ____ Physical ____ Emotional ____ Verbal ____ Neglect

Other childhood issues? _____

Young Adult/Adult

Have you experienced sexual assault as an adult? ____ Yes ____ No

Have you been or are you now in an abusive relationship? _____

physical? ____ sexual? ____ verbal? ____ psychological/emotional? ____

Trauma

Were there any other traumatic events in childhood or adulthood? _____

Medical/Physical Health

- | | | |
|----------------------|-----------------------------|-------------------------|
| ____ Aids | ____ Dizziness | ____ Nose Bleeds |
| ____ Alcoholism | ____ Drug Abuse | ____ Pneumonia |
| ____ Abdominal Pain | ____ Epilepsy | ____ Rheumatic Fever |
| ____ Abortion | ____ Ear Infections | ____ STD |
| ____ Allergies | ____ Fainting | ____ Scarlet Fever |
| ____ Anemia | ____ Fatigue | ____ Sore Throat |
| ____ Appendicitis | ____ Frequent Urination | ____ Sleeping Disorders |
| ____ Arthritis | ____ Headaches | ____ Sinusitis |
| ____ Asthma | ____ Hearing Problems | ____ Smallpox |
| ____ Bronchitis | ____ Hepatitis | ____ Sexual Problems |
| ____ Bed Wetting | ____ High Blood Pressure | ____ Tonsillitis |
| ____ Cancer | ____ Kidney Problems | ____ Tuberculosis |
| ____ Chest Pain | ____ Measles | ____ Toothache |
| ____ Chronic Pain | ____ Mononucleosis | ____ Thyroid Problems |
| ____ Colds/Coughs | ____ Mumps | ____ Vision Problems |
| ____ Constipation | ____ Menstrual Pain | ____ Vomiting |
| ____ Chicken Pox | ____ Miscarriages | ____ Whooping Cough |
| ____ Dental Problems | ____ Neurological Disorders | ____ Other (describe): |
| ____ Diabetes | ____ Nausea | _____ |
| ____ Diarrhea | | |

Medications

Current Prescribed Medications	Dose	Date	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Over the Counter Meds	Dose	Date	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ____ Yes ____ No

Most Recent Doctor Examinations:	Date	Reason	Results
Last Physical Exam	_____	_____	_____
Last Doctor's Visit	_____	_____	_____
Last Vision Exam	_____	_____	_____
Last Hearing Exam	_____	_____	_____
Most Recent Surgery	_____	_____	_____
Other Surgery	_____	_____	_____
Upcoming Surgery	_____	_____	_____

Family History of Medical Problems: _____

Please check if there have been any changes in the following:

____ Sleep Patterns ____ Eating Patterns ____ Weight ____ Energy Level
____ Physical Activity Level ____ General Disposition ____ Behavior ____ Tension

Describe changes in areas in which you checked above: _____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower
____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

Other (specify): _____

Chemical Use History:

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	
Barbiturates	_____	_____	_____	_____	_____	_____	_____	
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	
Marijuana	_____	_____	_____	_____	_____	_____	_____	
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	
Inhalants	_____	_____	_____	_____	_____	_____	_____	
Caffeine	_____	_____	_____	_____	_____	_____	_____	
Nicotine	_____	_____	_____	_____	_____	_____	_____	
Over the Counter	_____	_____	_____	_____	_____	_____	_____	
Prescription Drugs	_____	_____	_____	_____	_____	_____	_____	
Other Drugs	_____	_____	_____	_____	_____	_____	_____	

Substance of preference:

1. _____ 2. _____

3. _____ 4. _____

Substance Abuse Questions:

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perception of your use): _____

Reasons for Use:

____ Addicted ____ Build Confidence ____ Escape ____ Self-Medication
____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family have/had a problem with drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Employment:

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left Job	How Often Miss Work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired
____ Social Security ____ Student ____ Other (describe): _____

Education:

Years of Education _____ Currently Enrolled in School? ____ Yes ____ No

____ High School Grad/GED

____ Vocational: Number of Years ____ Graduated ____ Yes ____ No Major: _____

____ College: Number of Years ____ Graduated ____ Yes ____ No Major: _____

____ Graduate: Number of Years ____ Graduated ____ Yes ____ No Major: _____

Other training: _____

Legal:

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If yes, please describe: _____

Are you presently on probation or parole? ____ Yes ____ No

If yes, please describe: _____

Any current or history of being a sexual perpetrator? ____ Yes ____ No

If yes, please describe: _____

Military

Military Experience? ____ Yes ____ No Combat Experience? ____ Yes ____ No

Where? _____ Branch _____ Date enlisted _____

Date Discharged _____ Type of Discharge _____ Rank at Discharge _____

Leisure/Recreational

Describe special area of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, diet/health, fishing, bowling, traveling, etc.)

Activity	How Often Now?	How Often in the Past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check symptoms and behaviors that occur to you more often than you would like:

- | | | |
|--------------------------|--------------------------|----------------------------|
| ____ Aggression | ____ Elevated Mood | ____ Recurring Thoughts |
| ____ Alcohol Dependence | ____ Fatigue | ____ Sexual Addiction |
| ____ Anger | ____ Gambling | ____ Sexual Difficulties |
| ____ Antisocial behavior | ____ Hallucinations | ____ Sick Often |
| ____ Anxiety | ____ Heart Palpitation | ____ Sleeping Problems |
| ____ Avoiding People | ____ High Blood Pressure | ____ Speech Problems |
| ____ Chest Pain | ____ Hopelessness | ____ Suicidal Thoughts |
| ____ Cyber Addiction | ____ Impulsivity | ____ Thoughts Disorganized |
| ____ Depression | ____ Irritability | ____ Trembling |
| ____ Disorientation | ____ Loneliness | ____ Withdrawing |
| ____ Distractibility | ____ Memory Impairment | ____ Worrying |
| ____ Dizziness | ____ Mood Shifts | ____ Other (specify) _____ |
| ____ Drug Dependence | ____ Panic Attacks | _____ |
| ____ Eating Disorder | ____ Phobias/fears | _____ |

Discuss how the above symptoms impair your ability to function effectively:

Any additional information that would help us in understanding your problems or concerns?

What are your goals for therapy? _____

Are you suicidal at this time? ____ Yes ____ No

If Yes,

explain: _____

For Staff Use:

Therapist's Signature/Credentials _____ Date ____/____/____

Supervisor's

Comments: _____

Supervisor's Signature/Credentials _____ Date ____/____/____

Insurance Information: Please check with your insurance carrier regarding mental health coverage. Also, ask about your co-pay and deductible.

Primary Insurance:

Primary Insurance Carrier _____
Policy Holder _____ Relationship to Client _____
ID# _____ Group # _____
Co-Pay _____ Deductible _____

Secondary Insurance:

Secondary Insurance Carrier _____
Policy Holder _____ Relationship to Client _____
ID# _____ Group # _____
Co-Pay _____ Deductible _____

Insurance Billing: I authorize Indigo Counseling Center to release any medical information to my insurance company that may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Indigo Counseling Center. I understand that I am responsible for payment of services rendered by Indigo Counseling Center regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify Indigo Counseling Center immediately whenever my insurance coverage changes.
Signature: _____ Date: _____

Credit Card on File: Indigo Counseling requires a credit card on file. I hereby give my consent to charge my credit card for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier deems payable by me. **Cancellation Policy:** Indigo Counseling requires 24 hour cancellation notice. I hereby give consent to charge my credit card on file for missed (\$100.00) or late cancel (\$85.00) appointments.

Card Type: Visa ___ Master Card ___ American Express ___ Discover ___
Card Holder Name _____
Card Number _____
Exp. Date _____ CVV Code _____ Billing Zip Code _____
Card Holder Signature _____ Date _____

Private Pay: All payments are due at beginning of each session. Private pay session amount is:
\$ _____ Signature _____

Fees

Intake Session: 90791, 50-55 minutes, \$225.00
Individual Therapy: 90837, 53+ minutes, \$175.00
Individual Therapy: 90834, 38-52 minutes \$150.00
Couples/Family Therapy, 90847 53+ minutes \$175.00
Group Therapy, 90853, 60+ minutes \$55.00

Fees Not Billable to Insurance:

Late Cancel (less than 24-hour notice): \$85.00
No Show: \$100.00
Returned Check: \$30.00
Phone Calls, Letters, Reports, Consultation: \$43.75 per fifteen minutes/\$175.00 per hour
Telephone Consultation: \$43.75 per fifteen minutes/\$175.00 per hour

Limits of Confidentiality:

Content of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

--**Duty to Warn and Protect:** When a client discloses intentions to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

--**Abuse of Children and Vulnerable Adults:** If a client states or suggests he or she is abusing a child or vulnerable adult, the mental health professional is required to report this information to the appropriate authorities.

--**Court Order:** A court order, subpoena, or other legal process.

--**Prenatal Exposure to Controlled Substances:** Mental health care professionals are required to report prenatal exposure to controlled substances to the appropriate authorities.

--**Insurance Providers** (When applicable): Insurance providers and other third party payers are given information that they request regarding services to clients. Information that may be requested may be: types of services, dates/times of services, diagnosis, treatment plan, progress in therapy, case notes and summaries.

I have read and understand the **Limits of Confidentiality:**

Signature _____ **Date** _____

CLIENT NOTICE OF PRIVACY PRACTICES: This notice describes how your health may be used and disclosed and how you are able to access this information. Please review it carefully. Protecting our client's privacy has always been important to this practice. A new federal and state law entitled the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Indigo Counseling Center, we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a physician specialist, with whom we may involve in your care plan. We may use or disclose your health information for payment for your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff members will enter your information into our computer. We may share your medical information with our business associates, such as a billing representative or service. We have a written contract with each business associate which requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about appointments. If you are not home, we may leave this information on your answering service or with the person who answers the telephone unless you have instructed us otherwise. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will advise you if we are able to fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Supply us, in writing, your request to make changes. If you request to include a statement in your file, please submit it to us in writing. We reserve the right to make the changes or not, however, we will accommodate your request by including your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes, in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Indigo Counseling Center, owner, Joan Hause at 612-293-5124.

I have read and understand the HIPAA/Privacy Practices:

Signature _____ Date _____

Court and Legal Proceedings:

Indigo Counseling Center does NOT provide disability determination, custody studies or handle court issue. Indigo Counseling Providers do not perform court evaluation, nor do they appear in court on behalf of children, or adults. Indigo Counseling Center providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

If we are forced to further document or respond to information requests, meet with your representative, or testify in court, our fees are \$400.00 per hour, plus all expenses, half-day minimum, paid in advance.

Consultation and Supervision: To provide you with the best possible service, Indigo Counseling Center providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in other forums, confidentiality is protected.

After Hours Emergencies: Indigo Counseling Center clinicians are not available for after-hour emergencies. Messages are checked week days from 9:00 to 5:00. For after hour emergencies, if you need immediate assistance, call 911 or these crisis phone numbers:

Crisis Connection: 612-379-6363

National Suicide Prevention Lifeline: 1-800-273-8255

Riverwind Crisis Services: 763-755-3801

Dakota County Crisis: 952-891-7171

Ramsey County Crisis: 651-266-2700

Hennepin County Crisis: 612-596-1223

I understand and agree to abide by the policies stated above.

Signature _____ Date _____

Teletherapy Policy and Consent

I hereby consent to engaging in online counseling services with the therapist I am working with at Indigo Counseling Center. Teletherapy services may be engaged in situations such as :

1. Weather that causes hazardous driving conditions.
2. Illness or medical treatment that makes it difficult for in-person sessions.
3. Loss of transportation or difficulty making it to in-person appointments.
4. Travel that causes consecutive weeks of missed appointments.

Patient Confidentiality, Privacy and Safety

Teletherapy is provided through a HIPAA compliant online service to protect client's privacy. The therapist will use a secure online service and will interact with client from a private location. The client will also be responsible for ensuring a private setting on their end for the therapy.

All information during the teletherapy session is confidential and protected. Similar to in-person therapy, however, there are limits to confidentiality. These limits include reporting child or vulnerable adult abuse, expressing imminent harm to oneself or others, or as required by a court of law.

I understand that despite using a privacy protected service, there are still breach of privacy risks such as: the transmission could be disrupted or distorted by technical failure, the transmission could be interrupted by unauthorized persons.

Teletherapy sessions will not be recorded or videotaped by the therapist or client. For privacy reasons, I agree not to record or videotape any therapy sessions.

I agree to let my therapist know the address I am located at in case of an emergency situation arising such as ill health, or mental health distress.

Billing and Cancellations

Teletherapy is billed as a regular appointment. It is billable to insurance or private pay rates apply. 24-hour cancellation notice is required. \$100.00 no show, \$85.00 late cancel (less than 24 hours) are assessed to client.

Discontinuation of Teletherapy Services

Teletherapy services may be discontinued by the therapist or client. The therapist may decide that the client would be better served by in-person sessions. The client may also discontinue

services. Services may be discontinued if privacy or confidentiality are not established, or if technical issues interfere with communication.

I have the right to discuss any of this information with my therapist and to have any questions I may answered to my satisfaction.

I have read and understand the information provided above. My signature below indicates I have read this agreement and agree to its terms.

Client Signature

Date

Therapist Signature

Date