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
_____Alcoholism
_____Abdominal Pain
_____Abortion
_____Allergies
_____Anemia
_____Appendicitis
_____Arthritis
_____Asthma
_____Bronchitis
_____Bed Wetting
_____Cancer
_____Chest Pain
_____Chronic Pain
_____Colds/Coughs
_____Constipation
_____Chicken Pox
_____Dental Problems
_____Diabetes
_____Diarrhea
_____Dizziness
_____Drug Abuse
_____Epilepsy
_____Ear Infections
_____Fainting
_____Fatigue
_____Frequent Urination
_____Headaches
_____Hearing Problems
_____Hepatitis
_____High Blood Pressure
_____Kidney Problems
_____Measles
_____Mononucleosis
_____Mumps
_____Menstrual Pain
_____Miscarriages
_____Neurological Disorders
_____Nausea
_____Nose Bleeds
_____Pneumonia
_____Rheumatic Fever
_____STD
_____Scarlet Fever
_____Sore Throat
_____Sleeping Disorders
_____Sinusitis
_____Smallpox
_____Sexual Problems
_____Tonsillitis
_____Tuberculosis
_____Toothache
_____Thyroid Problems
_____Vision Problems
_____Vomiting
_____Whooping Cough
_____Other (describe):
_____

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 Yes	Used in last 48 hours No	Used in last 30 days Yes	Used in last 30 days No
Alcohol	_____	_____	_____	_____	___	___	___	___
Barbiturates	_____	_____	_____	_____	___	___	___	___
Valium/Librium	_____	_____	_____	_____	___	___	___	___
Cocaine/Crack	_____	_____	_____	_____	___	___	___	___
Heroine/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 your 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
_____Alcohol Dependence
_____Anger
_____Antisocial behavior
_____Anxiety
_____Avoiding People
_____Chest Pain
_____Cyber Addiction
_____Depression
_____Disorientation
_____Distractibility
_____Dizziness
_____Drug Dependence
_____Eating Disorder
_____Elevated Mood
_____Fatigue
_____Gambling
_____Hallucinations
_____Heart Palpitation
_____High Blood Pressure
_____Hopelessness
_____Impulsivity
_____Irritability
_____Loneliness
_____Memory Impairment
_____Mood Shifts
_____Panic Attacks
_____Phobias/fears
_____Recurring Thoughts
_____Sexual Addiction
_____Sexual Difficulties
_____Sick Often
_____Sleeping Problems
_____Speech Problems
_____Suicidal Thoughts
_____Thoughts Disorganized
_____Trembling
_____Withdrawing
_____Worrying
_____Other (specify)_____
_____

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 breech 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**

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	