WATERS EDGE
COUNSELING & THERAPEUTIC SERVICES

Patient Intake Packet

Today's Date: _____

A thorough assessment is important because it can provide your counselor with helpful information about your background and because most insurance policies and other third-party payers require that counselors collect this information. In an effort to ensure that our counselors can spend time in-session focusing on what is most important to you instead of collecting this information, we ask that you complete this packet and bring it with you to your first appointment.

Patient Information

Name: _____ Social Security Number: _____

Address: _____ Birth Date: _____ Age: _____

City/State/Zip: _____ Gender: ❑ Male ❑ Female

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____

Emergency Contact: _____ Phone: _____

Do you have a primary care physician? Do you have health insurance? ❑ No ❑ Yes

❑ No ❑ Yes; Name of Physician/Practice: _____

How did you hear about Waters Edge: _____

May we...

Leave messages at the above phone numbers? ❑ No ❑ Yes

Send appointment reminders via text message to the above cell number? ❑ No ❑ Yes

Contact you via email if we cannot reach you by phone? ❑ No ❑ Yes

Verify your insurance benefits? ❑ No ❑ Yes

File claims with your insurance company or other payer? ❑ No ❑ Yes

Goals

Briefly describe the issues/problems that led you to counseling today:

_____

_____

What goals would you like to achieve with counseling:

_____

_____

Checklist of Concerns

Please mark all of the items below that apply:

- ❑ Abuse - physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use - prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems - overeating, undereating, appetite, bulimia (see also “Weight and diet issues”)
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Sexual issues - dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems - too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress - relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores - quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict - distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition

Any other concerns or issues not listed in the Checklist of Concerns:

What concerns do you most want help with:

Family History

Were you adopted? ❑ No ❑ Yes

Who lived with you growing up?

Did you have brothers or sisters? ❑ No ❑ Yes; list their names and ages:

Did/do you have stepparents? ❑ No ❑ Yes

How would you describe your family growing up?

What was your parents' relationship with each other like?

What was your relationship with your mother like growing up?

What is your relationship with mother like now (if living)?

What was your relationship with your father like growing up?

What is your relationship with father like now (if living)?

Did you experience physical, emotional, sexual abuse or neglect as a child or as an adult? ❑ No ❑ Yes; Describe:

What is your relationship status (check all that apply)?

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Dating ❑ Co-habitating ❑ Other:

Do you have children? ❑ No ❑ Yes; Names and ages:

Psychosocial History

Family Psychiatric History - Has anyone in your family ever been diagnosed or treated for a mental health disorder or for an alcohol- or drug-related problem? Has anyone had these problems but not been treated? If either apply, please indicate below:

Family Member	*Problem/Disorder*	*Describe Treatment (if any)*

Trauma History - Did you experience any physical, sexual, or emotional/psychological abuse or neglect during childhood or as an adult? If so, please describe:

Have you had any experiences you'd consider to be traumatic (e.g., threat of serious harm/injury, natural disaster, victim of a crime, traumatic losses/deaths, etc.)? If so, please describe:

Treatment History - Have you ever participated in counseling, psychotherapy, psychiatric/mental health treatment, or substance abuse treatment? If so, please complete the following information to the best of your ability:

Date (M/Y)	*Provider, Purpose/Focus of Treatment, Outcome*

Medical Conditions & History

Current and/or Recent - Do you have any current or recent medical/physical concerns?

❑ No ❑ Yes; Describe

Please list any history of surgeries, significant medical procedures, ER visits, or major illnesses (include dates if possible):

Medications (including dosages, prescribing physician, and purpose of medication):

Allergies:

Substance Use

Please enter the following information for any substances including alcohol, tobacco, and drugs that you currently use or have used in the past:

Substance	*Past*	*Current*	*How often/how much?*
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	

Social, Spiritual, & Developmental History

Where were you born? _____

Where did you live growing up? _____

Were there any complications with your birth? _____

Were there any developmental delays growing up? _____

What were your friendships like growing up? _____

Describe your friendships now: _____

Who do you turn to for support? _____

How many serious relationships have you been in your life? _____

Describe your history of romantic relationships: _____

Are you in a relationship now? ❑ No ❑ Yes; If so, for how long? _____

Describe your relationship with your significant other: _____

Describe your sexual orientation:

❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Pansexual ❑ Questioning ❑ Asexual ❑ Other:

Describe your religious or spiritual beliefs: _____

Describe any social groups or institutions you are involved in (e.g., clubs, associations, congregations):

_____

What do you do in your spare time? _____

_____

What are your strengths? _____

_____

Educational & Vocational

What was school like for you growing up? _____

What is the highest level of education/highest grade you completed? _____

If you went to college or grade school, what degrees or certifications did you earn? _____

_____

Describe your employment history: _____

Are you working now? ❑ No ❑ Yes

What is your occupation? _____ Annual income? _____

Describe any vocational/occupational goals you may have for the future: _____

_____

Legal History

Have you ever been arrested? ❑ No ❑ Yes; If so, when and what charge(s)?

Describe any current legal concerns:

Other Information

Anything else you want us to know?

WATER'S EDGE COUNSELING & THERAPEUTIC SERVICES, LLC
POLICIES AND CONSENT TO TREATMENT

FINANCIAL POLICY Full payment is due at time of service (unless prior arrangements have been made). Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. Insurance is a contract between you and your insurance company. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e., diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice. Uncollected balances may be turned over for collection or reported to the state's attorney's office.

CANCELLATION POLICY Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so we can offer that time to someone else. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal counseling session. This will be billed to you. We may require prepayment in order to schedule a subsequent appointment.

CONFIDENTIALITY Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Integrity Counseling, Inc. without your written permission, except as required by law or as needed to file your insurance claim. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

CONSENT TO TREATMENT I am voluntarily seeking outpatient counseling at Water's Edge Counseling & Therapeutic Services. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at Integrity.

Individual counseling sessions are intended to be 45-52 minutes in length. Please note: We do not provide emergency services. In true crisis, call 911.

With my signature, I acknowledge that I understand the above information and consent to treatment at Water's Edge Counseling & Therapeutic Services.

Client's Signature: _____ Date: _____

❑ *Electronic Signature (If typing this document, check this box to affix electronic signature)*

Client's Name (print): _____

Parent/Guardian's Signature: _____ Date: _____

❑ *Electronic Signature (If typing this document, check this box to affix electronic signature)*

Parent's/Guardian's Name (print): _____