Waters Gone By Counseling, LLC

Amy S. Orlovich, MA, LCPC

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Intake Form

CLIENT INFORMATION

_________________________________ _________________________________
Last Name First Name

___________________________ ______/______/______ ______/______/______
Preferred Name Date of Birth Date of Form Completion

I identify my gender as (fill in the blank, or write "prefer not to say"): ______________________

_____________________________________ _____________ _____ __________
Street Address City State Zip Code

___________________________ ___________________________ ____________
Email Address Preferred Phone Number Type of Phone

May we leave messages & appointment reminders on your preferred phone (circle)? Yes No

May we send text messages to your preferred phone (circle)? Yes
No

May we contact you at the given email address (circle)? Yes
No

If you choose to engage in electronic communication with me (emails, phone calls, voicemail, text messages, etc.) please note that *I cannot guarantee 100% confidentiality*. I go to great lengths to encrypt and secure these communications, but there is still a risk associated with utilizing these forms of communication.

INITIAL to acknowledge that you understand the risk in electronic communication: ______

EMERGENCY CONTACT: (if you or your child needs a ride home or is in danger)

______________________________	________________________	________________________
Emergency Contact Name	Emergency Contact Phone	Relationship to Contact

RELATIONSHIP STATUS: (circle all that apply)

SINGLE MARRIED COHABITATING SEPARATED DIVORCED ENGAGED OTHER

OTHERS IN YOUR HOME:

- Spouse/Partner (name): ____
- Children Names/Ages: ____

  ____

  ____
- Parent/s (name/s): ____
- Siblings (names and ages): ____

  ____

  ____
- Others (names and relationships): ____

  ____

  ____
- Pets: ____

EMPLOYMENT INFORMATION:

____ ________________________
Current Employer Job Title/Occupation

____ ________________________
Employer Address Employer Phone Number

REFERRAL INFORMATION:

Who referred you to Amy at Waters Gone By Counseling? ______________________________

RESPONSIBLE PARTY (if under 18):

____ _______/_______/______________
Full Name Date of Birth

____ ___________________
Street Address City State Zip Phone Number

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under this Agreement. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to ***Waters Gone By***.

- Intake Session (first session): **$175**
- 60 Minute Session: **$160**
- 45 Minute Session: **$125**

I will self-pay for services at Waters Gone By Counseling. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided. Please sign below.

Client Name (Printed): ____

____ _______/_______/_______
Client/Parent/Guardian Signature Today's Date

INSURANCE INFORMATION: (please bring your insurance card with you for your first session)

Primary Insurance:

____

Name of Primary Insurance

____

Phone Number of Eligibility Verification (*usually don't found on back of card)*

__________________________ __________________________

Member ID # Group #

_____________________ ________/________/________ _____________________

Subscriber Name (if other than self) Subscriber Date of Birth Subscriber Phone #

_____________________ _____________________

Subscriber's Employer Subscriber Relation to Client

____

Subscriber Street Address City State Zip

Secondary Insurance:

____

Name of Secondary Insurance

____

Phone Number of Eligibility Verification (*usually don't found on back of card)*

__________________________ __________________________

Member ID # Group #

_____________________ ________/________/________ _____________________

Subscriber Name (if other than self) Subscriber Date of Birth Subscriber Phone #

_____________________ _____________________

Subscriber's Employer Subscriber Relation to Client

____

Subscriber Street Address City State Zip

Have you seen other therapists or used an EAP in the last calendar year? ***YES*** ***NO***

If yes, how many sessions were used? _______________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Waters Gone By, LLC/Amy S. Orlovich, LCPC. I understand that I am financially responsible for any balancethat insurance does not cover. I also authorize Waters Gone By, LLC to release necessary information to the insurance company that is required to process my claim.

I understand that payment towards deductible and/or co-payment is due at the time of service.

Client Name (Printed): ____

____ ________/________/________

Client/Parent/Guardian Signature Today's Date

HEALTH INFORMATION:

____ _______________________________

Primary Care Physician Affiliated Clinic

____ _______________________________

Address Phone #

Current/Past Medical Conditions (major illness/surgeries/allergies):

____

____

____

____

____

____

____

____

Are you currently taking prescribed or over the counter medications (circle)? YES NO

If yes, please list below (use an additional sheet of paper if necessary):

Name of Medication	Dosage & Frequency	Purpose

AUTHORIZATION TO RELEASE INFORMATION TO PRIMARY PHYSICIAN:

I authorize Amy S. Orlovich to communicate directly with my primary care physician via phone, fax, or written communication for evaluation, referral, treatment planning, medication management consultation and the coordination of care. I understand that this authorization may be revoked upon my request, and will terminate within one year of the date signed below.

Client Name (Printed): ____

____ ________/________/________

Client/Parent/Guardian Signature Today's Date

PREVIOUS MENTAL HEALTH INFORMATION:

Counseling: ____

Psychiatric Hospitalizations:____

WHAT IS THE PRIMARY REASON YOU'RE SEEKING COUNSELING?:

____

____

SYMPTOM CHECKLIST: (please check all that apply)

Sadness		Helplessness		Flashbacks		Mental blankness or "spaciness"	
Tearfulness		Fearful		Intrusive thoughts		Feelings of wanting to harm others	
Hopelessness		Panic attacks		Feeling Numb		Eating problems	
Guilty/Worthless		Unusually high mood		Exaggerated emotional/ startle response		Aggression	
Irritable		Anxiety/stress		Mood changes		Bullying	
Diminished interest in life		Phobias		Lack of need for sleep		Addiction	
Fatigue		Restless		Hyperactivity		History of physical or sexual assault	
Outbursts of anger		Racing thoughts		Impulsive behaviors		Grief/loss/death	
Suicidal thoughts		Muscle tension		Increased goal directed activity		Relationship stress	
Cutting/injuring self		Stomachaches		Increased desire for sex		Divorce/separation/breakup	
Change in appetite		Headaches		Increased high risk behaviors		Spiritual concerns	
Too much sleep		Too little sleep		Paranoia		Parenting concerns	
Hard to fall asleep		Easily annoyed		Rapid speech		Life transition	
Poor memory		Compulsions		Impulsive shopping		Financial concerns	
Difficulty making decisions		Obsessive thoughts		Procrastination		Problems with sex	
Lack of interest in sex		Hoarding		Hear things		Problems with school	
Don't like all or part of self		Nightmares, weird dreams		See things		Problems with work	
Adjustment to new situation		Excessive worry		Legal difficulties		Immune system problems	
Other (please list):							

Approximately how long have these symptoms been bothering you? (please check)

___ Less than a month ___1-6 months ___6 months to 1 year ___More than a year

How much distress do these symptoms have on your life? (please check)

___Little distress (a couple of days a month) ___Minimal distress (1-2 days/week)

___Moderate Distress (3-5 days/week) ___ Severe distress (5-7 days/week)

What functional areas do these symptoms affect? (please check all that apply)

___Family ___Finances
___Social/Friends ___Schooling
___Vocational ___Chores/Daily Tasks

___Legal ___Other: ____________________

What supports/strengths do you have that will assist you during therapy? (check all that apply)

___Family ___Coworkers
___Friends ___Pets
___Church ___Clubs
___Groups ___Other: ____________________

Would including spirituality/religion in your counseling be beneficial?

______Yes ______No ______Not sure

Is there anything else you want Amy to know before your first session?:

____

____

____

____

____