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): $140
- 60 Minute Session: $120
- 45 Minute Session: $90

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
___Friends
___Church
___Groups
___Coworkers
___Pets
___Clubs
___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?:

_____

_____

_____

_____

_____