Client Intake Face Sheet

Client Name: ______________________________________ Date of Birth: _______________

Address: ____

Email Address: ____

Employed by:___________________________________ Occupation: ____________________

Marital Status S___ M___ D___ W___ Sep___ Spouse/Significant Other Name __________

Emergency Contact Name: ____________________________ Phone: _____________________

Referred By: ____

Allergies: ____

Reason for seeking treatment: ____

Contact Preference: ☐ Phone: _____________________________

☐ Text: ______________________________

☐ Email: _____________________________

Patient Signature: _______________________________________

Medical Information

Insurance Provider: __________________________ Insurance ID #: ______________________

Primary Care Provider: ___________________________ Phone: _________________________

Medical Problems (if applicable): ____

Pharmacy Name: _________________________________ Phone: _________________________

Review of Systems – check the box if you are **currently** experiencing any of these

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General/Endocrine

□Weight Change	□ Fever/Chills	□ Weakness/Paralysis
□ Night Sweats	□ Goiter	□ Lymph Node Enlargement
□ Sleep Problems	□ Freq. Infections	□ Heat/Cold Intolerance
	□ None	

Skin

□ Hair/Nail Changes	□Rashes/Eczema	□ Itching
□ Brittle Nails	□ Dry Skin	□ Hives
	□ None	

Head, Eyes, Ears, and Nose

□ Headache	□ Trauma	□ Vision Changes/Glasses
□ Blurring	□ Eye Pain/ Discharge	□ Ringing in the Ears
□ Ear Infections	□ Hearing Problems	□ Sinusitis
□ Postnasal Drip	□ None	

Mouth

□ Sores	□ Bleeding Gums	□ Loss of Taste
□ Hoarseness	□ Sore Throat/Infections	□ None

Lungs

□ Trouble Breathing	□ Chest Pain	□ Cough/Wheeze
□ Coughing Blood/Sputum	□ None	

Cardiovascular

□ Chest Pain	□ Palpitations	□ Murmur
□ Cyanosis (blue skin)	□ Leg Pain	□ Edema/Swelling
□ Cold Hands/Feet	□ Poor Circulation	□ Varicose Veins
□ Anemia	□ None	

Gastrointestinal

□ Change in Appetite	□ Hernia	□ Nausea/Vomiting
□ Indigestion/Heartburn	□ Gas/Bloating	□ Abdominal Pain
□ Diarrhea/Constipation	□ None	

Bones, Joints, Muscles

□ Arm Pain	□ Back Pain	□ Bursitis
□ Hip Pain	□ Numbness/Tingling	□ Neck Pain/Stiffness
□ Leg Pain	□ Muscle Pain	□ Joint Pain
□ Bone Pain	□ None	

Neurological

□ Fainting/Loss of Balance	□ Gait/Coordination Issues	□ Dizziness/Tremors
	□ None	

Genitourinary

□ Blood in the Urine	□ Pain	□ Incontinence
□ Increased Frequency/Urgency	□ Urination at Night	□ Prostate Problem
□ Decreased Sex Drive	□ None	

Pregnancy – Females Only

□ Pregnant	□ Trying to Become Pregnant	□ Birth Control (Type:______)

Client Signature/Authorized Representative: ______________________________________ **Date:** ___________

Current Medications

Name	Dosage and Frequency	Reason for Use	Date Started

Treatment History: Medical, Mental Health, Substance Abuse

Date	Treatment	Reason	Outcome

Family History of Mental Illness

Have you or anyone in your family been diagnosed or treated for:

Me		**Family Member**	**If yes, who?**
Bipolar Disorder	□ Yes □ No	□ Yes □ No	____________________________
Depression	□ Yes □ No	□ Yes □ No	____________________________
Anxiety	□ Yes □ No	□ Yes □ No	____________________________
Anger	□ Yes □ No	□ Yes □ No	____________________________
Violence	□ Yes □ No	□ Yes □ No	____________________________
Schizophrenia	□ Yes □ No	□ Yes □ No	____________________________
Posttraumatic Stress	□ Yes □ No	□ Yes □ No	____________________________
Alcohol Use	□ Yes □ No	□ Yes □ No	____________________________
Suicide	□ Yes □ No	□ Yes □ No	____________________________
Substance Abuse	□ Yes □ No	□ Yes □ No	____________________________

Substance Use

Drug	Frequency	Amount
Cocaine □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Opiates/Heroin □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Amphetamine □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Methamphetamine □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Ecstasy □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
PCP □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Molly □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Marijuana □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Tobacco □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	
Alcohol □ Never □ Active □ Quit (Date:____________)	□ _______ Daily □ _______ times per week □ _______ times per week □ _______ times per year	

Consent to Treatment

I consent to any psychotherapy, medication assessment and management, laboratory or other medical procedures or examinations rendered me under the general and specific instructions of Heart & Soul Community Counseling, Inc.

Initial here: ________________

Privacy Policy

Recognizing that certain services provided are of confidential nature, Heart & Soul Community Counseling, Inc. has formally adopted a policy to protect your privacy. This policy states that the information you provide to me will be kept confidential and will not be distributed or shared with other persons or organizations without your written approval. However, there are situations where Heart & Soul Community Counseling, Inc. has a responsibility to release information, regardless of whether the client agrees. These exceptions include:

1. Cases of suspected child abuse or neglect are required to be reported in the State of New York to the Department of Children and Families;
2. Cases of suspected abuse or neglect of the elderly or mentally challenged adults are required to be reported to the Stated of New York;
3. The courts have a right to order Heart & Soul Community Counseling, Inc. to release client information;
4. Heart & Soul Community Counseling, Inc. is required to make a reasonable effort to inform the police and any person directly threatened by a client, of the client's direct threat to harm that person;

It is Heart & Soul Community Counseling, Inc. policy to keep your information confidential and to protect your privacy. However, the enactment of the HIPAA privacy rule, section 164.505(b) requires that a client's right to have his/her health information kept private and secure has become more than just an ethical obligation of health professionals, it is also the law. As a result, we have established this formal in-house private policy. As always, we strive to provide you with the best services, along with keeping your personal information confidential.

Initial here: _______________

Release of Information and Confidentiality of Records

I authorize the release of information to my Primary Care Physician, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefits administration, and other purposes related to my health plan.

Initial here: _______________

Payment and Insurance Reimbursement

If your services are covered by insurance, you are responsible for obtaining prior authorization for treatment from your insurance carrier. Heart & Soul Community Counseling, Inc. will bill your insurance company, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Clients are expected to pay any fees due at the beginning of each session. I agree to alert Heart & Soul Community Counseling, Inc. immediately should my insurance status change at any time while I am enrolled. If I am currently not insured or become uninsured, I agree to pay all the charges incurred by me for services received.

Initial here: _______________

Cancellation Policy

Since scheduling an appointment involved the reservation of time specifically for you, a minimum of 24 hours cancellation notice is required for rescheduling or cancelling an appointment. **MISSED APPOINTMENTS ARE NOT COVERED BY YOUR INSURANCE AND THEREFORE THE CHARGES ASSOCIATED WITH THEM ARE YOUR RESPONSIBILITY. If 24 hours cancellation notice has not been given, there will be a $90 charge and this fee must be paid prior to the beginning of the next scheduled appointment**. This policy is necessary in order to make the time available to other clients.

Initial here: _______________

Medication Management / Refill Request / Changes in Medication

When treatment involves medications, you will be provided with enough prescription refills to last until your next scheduled appointment. If you need to cancel that appointment, you will need to reschedule before your medication runs out. Medication changes will not be made over the phone as a proper face-to-face evaluation will be necessary to determine a change in the course of care. If you have questions about your care, please write them down to be sure they get addressed at your next meeting. If an emergency occurs between visits, please call 911 or go to the nearest emergency room for an evaluation. Patient expectations for safe and effective medication management require that the client:

1. Inform Heart & Soul Community Counseling, Inc. when any new medical problems or medication that is prescribed by other healthcare providers, and of any over-the-counter medications or supplements you are using.
2. Inform Heart & Soul Community Counseling, Inc. of any side effects or suspected side effects of medication at every visit.
3. Agree not to make changes in medication dosing, including stopping medications without consulting with Heart & Soul Community Counseling, Inc., for medications prescribed by Heart & Soul Community Counseling, Inc. **NOTE: IT MAY BE DANGEROUS TO ABRUPTLY STOP MEDICATIONS OR CHANGE DOSING WITHOUT CONSULTATION WITH A MEDICAL PROFESSIONAL**.
4. Attend all scheduled appointments as agreed upon in order to provide proper continuity of care and to properly assess efficacy of treatment.
5. Complete all requested laboratory testing in a timely manner. Some medications cannot be safely prescribed without periodic blood work.

Initial here: _______________

HIPAA Authorization to Release and/or Exchange Information

NOTE: This authorization complies with the requirements of the HIPAA Privacy Act

Client Name: ____ DOB: ________________

Address: ____

I authorize the use or disclosure of my health information as described below:

1. Emergency Contact: Name/Phone Number: ____

2. Therapist/Counselor/Treatment Facility/Primary Care Physician:

________________________	____
Name	Address
________________________	____
Phone	Fax

□ Complete Medical Record □ Admission/Discharge Summaries

□ Plan of Care □ Treatment Notes

□ Other (specify) ____

The purpose for which the information will be used or disclosed: (the purpose may be stated as "at the request of the individual" if the individual initiates this authorization and does not provide a statement of purpose)

____

This authorization will expire on ______________, or continue for the duration of treatment at Heart & Soul Community Counseling, Inc.

I understand that I may revoke this authorization at any time, except to the extent the person/organization obtaining the authorization has already taken action in reliance on it by contacting Heart & Soul Community Counseling, Inc. in writing to express such revocation.

By signing below, I acknowledge that I have read and understood this authorization and that it will continue for the duration of my treatment with Heart & Soul Community Counseling, Inc.

____ __________________

Client Signature (or Authorized Representative/Relationship) Date