Sound Mind Counseling

CLIENT INFORMATION

First Name_____Middle Initial _____Last Name_____Nick Name_____

(Check one): ☐ M or ☐ F Date of Birth:__/__/__ Marital Status (check one): ☐ Married ☐ Single ☐ Other

Employment Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Retired ☐Other:_____

Home Address: _____

Street City Zip

Telephone numbers: HOME_____WORK_Work Extension_____ CELL_____

Email address: _____

How would you like appointment reminders sent to you?

☐ Text message (Requires cell number) _____

☐ Email (Requires en1ail address)

☐Phone call (Required Home phone number)_____

☐ None (No reminder will be sent)

How did you hear about us? ----------

IF CLIENT IS A MINOR, Names of parents or guardians who live with child:

Name_____(check one) ☐ Father, ☐ Mother, ☐ Other _____

Name_____(check one) ☐ Father, D Mother,☐ Other_____

Name(s) of parents who do not live withchild:_____

Address _____

Stree City Stat Zip

Whom shall we call in an emergency?_____Relationship to client_____

Telephone number(s):_____

Name of **person** responsible for payment:_____DOB_____

Address (if not listed above)_____ City_____Zip_____

Is it OK to keep charge card information in a secure file for future use? ☐ YES ☐NO

Reason for seeking counseling: _____, _____, _____

Date these symptoms or problems first appeared:__/____/_

If insurance is used, fill in this section

-

Primary Inst1rance Company_____ID #_____Group#_____

Telephone number for Mental Health information Authorization#_____

Insured person's name (Last, First, MI)_____

Insured person's Address: _____

Street City State Zip

Insured person's Date of Birth (e.g., 1/1/21)_____Insured person's Employer_____

Relation of insured to the Client: ☐Self ☐Spouse ☐Child ☐Other:_____

Sound Mind Counseling

DISCLOSURES

Gene1·ally, tl1e information you provide will be confidential and cannot be disclosed without your consent. Tl1ere are exceptions to the general rule of confidentiality. These exceptions are listed in the Florida Statutes (Title XXXII, Chapter 491, Section 491.0147). We will identify other exceptions to you as situations arise during therapy. You need to know that all child and elder abuse situations and suicide and homicide plans must be reported.

Our "Privacy Policies Statement" is available for download and printing on our website. Additionally, paper copies are available in our office waiting room. Your signature below indicates that you have had an opportunity to read and understand this document and that you agree to its stipulations. Our staff will be glad to explain any parts that are unclear to you.

The Florida Department of Health Medical Quality Assurance Board of Clinical Social Workers, Mental Health Counselors, and Marriage and Family Tl1erapists has the general responsibility of regulating the practice of licensed individuals who practice psychotherapy. As a participant in the psychotherapy process, you need to be informed of the following:

1. Our practice· emphasizes family systems and behavioral therapy principles. The focus of treatment will be on determining goals for successfully completing therapy and discussing strategies to help you achieve those goals. The duration of psychotherapy is typically 20-30 sessions.
2. You can seek a second opinion from another psychotherapist or terminate therapy at any time.
3. We may consult witl1 other clinicians at Sound Mind Counseling if existing to maximize the effectiveness of treatment.
4. Psychotherapy is not an exact science; therefore, no guarantees can be made regarding the process or outcome of the services.
5. All personal information is stored electro11ically and protected according to current HIPPA guidelines.
6. We are members of several provider networks and groups, and members of those groups cannot be held liable or responsible for your therapy process outcome.
7. Our emergency system involves a pre-recorded message on voice mail system with instructions advising callers to call 911. If a client feels the need is to talk only to a therapist, leave a message, and a counselor will call back as soon as possible.
8. Florida law requires that when biological parents are divorced from each other, both must consent in writing to the treatment of a minor child before a child is presented for psychotherapy. It is the responsibility of the presenting parent to notify and obtain consent from the absent parent. Sound Mind Counseling, Inc. and its associates and staff do not take responsibility for notifying parents and cannot be held liable for any failure to notify parents.
9. In a professional relationship such as ours, sexual intimacy between a psychotherapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board. Furthermore, any personal relationship beyond the scope of psychotherapy is strictly forbidden for a minimum of three years after psychotherapy has ended.
10. I affirm that I have been given an opportunity to read the Sound Mind Counseling, Inc. *Privacy Practices* statement.

☐ I Accept OR ☐ Do NOT Accept these disclosures.

_____ _____

Client or Legal Guardian's Name Date

Sound Mind Counseling

INFORMED CONSENT

In compliance with national standards of ethics, Sound Mind Counseling, Inc. is required to disclose all billing and financial matters regarding psychotherapy services. As a client of Sound Mind Counseling, Inc., you understand:

1. Usual and customary rates for providing direct face-to-face psychotherapy services are $125.00 to $150.00 per 45–50-minute session.
2. **All the income that supports Sound Mind Counseling, Inc and its therapists and staff is entirely dependent upon clinical hours completed. Therefore, it is critically important that if you need to cancel your appointment, please call and give 24-hours notification. This notification allows us to attempt to fill the time slot with clients needing a sooner appointment. Clients not giving 24-hours' notice will be billed $100.00 for the missed appointment (Late Cancellation Fee), and this fee must be paid before the next appointment. More than two missed appointments or late cancellations will require a $100.00 deposit prior to any further session being scheduled.**
3. Late arrival by more than 15 minutes may be considered a No-Show and, therefore, may result in not being seen and being charged a late cancellation fee accordingly. **Please call our office to notify us that you are running late.**
4. Our office answering machine is secure, and you may leave confidential information with confidence.
5. Your insurance company/managed care company reimburses services at a rate depending on the insurance plan. You agree to pay for any charges that are not paid by your insurance company, regardless of the reason for denial of payment.
6. Your fee or co-payment is due prior to services being rendered.
7. You will be billed for non-covered and non-routine services such as extended telephone consultation, crisis intervention, report writing, and/or extended care coordination with other providers. You will be informed of the charges for such services.
8. Copies of a client's chart will be furnished to clients or other medical or mental health caregivers at the written request of the Client at no charge (authorizations to release records may be required). Other copies will be furnished at $3.00 per sheet.
9. **Our policy is not to provide legal testimony.** If compelled to provide testimony by court order, the Client will be billed at the rate of $250.00 per hour including driving time to and from the place of testimony and preparation for the testimony. A retainer of $1880.00 will be required.

☐ I Understand and Consent OR ☐ I Do NOT Consent

_____ _____

Client or Legal Guardian's Signature Date

Sound Mind Counseling

UNDERSTANDINGS AND AUTHORIZATIONS

Please read the following statements carefully. If you have questions, ask a member of our staff.

1. If I direct Sound Mind Counseling, Inc. (SMC) to file insurance claims for the Client, I authorize SMC to furnish such personal and clinical information as needed to process claims and receive payments. I understand that the confidentiality of such information given to insurance companies cannot be guaranteed. Therefore, I agree to hold harmless Sound Mind Counseling, Inc. and its staff and associates of any damages resulting from a breach in confidentiality that may occur as a result.

2. I understand that I have a right to request copies of my own confidential client file according to the requirements of the federal privacy protection regulations founded under 45 CFR 164.524. Requests must be in writing and may be denied in accordance with current HIPPA guidelines. The therapists treating the Client and the office staff may have access to the files. No other persons may have access to the files or information without my written consent. A form is available for the purpose of giving consent- "Authorization to Use and/or Disclose Protected Health Information."

3. I authorize SMC to mail correspondence or financial statements to the Client's home, **OR,**
   a. this address: _____

4. (Please check one):

   ☐ I authorize SMC, Inc. to receive payments for benefits from my managed care/insurance company:

   ☐ I prefer to pay the full fee at the time of service and have insurance payments come directly to the designated insurance subscriber or to me.

   i. (*If no check is made above, your choice will be considered as a choice to have SMC receive payments for you.)*

5. I understand that SMC, Inc. will make every effort to reach me with a reminder of my scheduled appointments; however, I do not hold SMC, Inc. responsible for any failure to reach me.

I understand and agree to these authorizations.

_____ _____

Signature of Client or Legal Guardian Date

Sound Mind Counseling

Credit Card Authorization

Client's Name:_____

Cardholder's Name (If different:)_____

I authorize Sound Mind Counseling, Inc. to charge my credit card or debit card for the Client(s) named above for professional services.

Type of Card: Visa MasterCard Discover

Card Number:____ _____ _____ _____

Exp. Date: _____ CVV Code:_____

Cardholder's billing address for Credit/Debit Card statements:

_____

Street City State Zip

Cardholder's Signature:_____Date :___/__/_____

Charges will appear on your credit card statement as Sound Mind Counseling, Inc.

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check to go quickly. You may need to ask family members about the family history. Thank you!

Name:_____ Date: _____

Date of Birth_____Primary Care Physician_____

Do you permit ongoing regular updates to be provided to your primary care physician?_____

Current Therapist/Counselor_____Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1. ----------
2. ----------
3. ----------

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) **Depressed mood**
( ) **Unable to enjoy activities**
( ) **Sleep pattern disturbance**
( ) **Loss of interest**
( ) **Concentration/forgetfulness**
( ) **Change in appetite**
( ) **Excessive guilt**
( ) **Fatigue**
( ) **Decreased libido**
( ) **Racing thoughts**
( ) **Impulsivity**
( ) **Increase risky behavior**
( ) **Increased libido**
( ) **Decrease need for sleep**
( ) **Excessive energy**
( ) **Increased irritability**
( ) **Crying spells**
( ) **Excessive worry**
( ) **Anxiety attacks**
( )**Avoidance**
( ) **Hallucinations**
( ) **Suspiciousness**
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts?_____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

How strong is your desire to kill yourself currently on a scale of 1 to 10 (ten being strongest)?_____

Would anything make it better? _____

Have you ever thought about how you would kill yourself?_____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies:_____ Current Weight:_____Height:_____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:_____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when_____.
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period_____Are you currently pregnant, or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant?_____How many live births?_____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease---------- -	( )	( )	_____
Chronic Fatigue---------- -	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ----- -	( )	( )	_____
Stomach or intestinal problen1s ---	( )	( )	_____
Cancer (type) ---------- -	( )	( )	_____
Fibromyalgia ---------- ----------	( )	( )	_____
Heart Disease_____	( )	( )	_____
Epilepsy or seizures ---------- -	( )	( )	_____
Chronic Pain----------	( )	( )	_____
High Cholesterol---------- -	( )	( )	_____
High blood pressure ---------- -	( )	( )	_____
Head trauma ---------- -	( )	( )	_____
Liver problems----------·	( )	( )	_____
Other- -	( )	( )	
	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, please describe when, by whom, and nature of the treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when, and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine)_____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine)_____

Wellbutrin (bupropion) _____

Remeron (mirtazapine)_____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Mood Stabilizers

Other_____

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Tegretol (ca1·bamazepine)_____

Topamax (topiramate)_____

Other_____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects

Seroquel (quetiapine) _____

Zyprexa (olanzepine)_____

Geodon (ziprasidone) _____

Abilify (aripiprazole) _____

Clozaril (clozapine) _____

Haldol (haloperidol) _____

Prolixin (fluphenazine)_____

Risperdal (risperidone) _____

Other_____

Sedative/Hypnotics

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon)_____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Other_____

ADHD medications

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Other_____

Antianxiety medications

Xanax (alprazolam)_____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise?_____

What kind of exercise do you do?_____

Family Psychiatric History:

Has anyone in your family bee11 diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem?_____

_____

Has any family member been treated with psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances?

If yes, where were you treated and when?_____

_____

How many days per week do you drink any alcohol?_____

What is the least number of drinks you will drink in a day?__ _

What is the most number of drinks you will drink in a day?__ _

What is the largest amount of alcoholic drinks you have consumed in one day in the past three months?_____

Have you ever felt you ought to cut down on your d1inking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past three months? ( ) Yes ( ) No

If yes, which ones?_____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long?_____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and \when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	()	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee_____ Sodas_____Tea____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average?_____How many years?____

In the past? ( ) Yes ( ) No How many years did you smoke? When did you quit?_____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind?_____How often per day on average?_____ How many years?_____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up?_____

List your siblings and their ages:_____

_____

What was your father's occupation? _____

What was your mother's occupation?_____

Did your parents divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

_____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____.

Who and when?

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? ( ) Yes ( ) No.

Please describe when, where, and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college?_____Where?_____Major?_____

What is your highest educational level or degree attained? _

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired How long in present position? _____

What is/was your occupation?_____

Where do you work? _____

Have you ever served in the military?____ If so, what branch and when?_____

An honorable discharge ( ) Yes ( ) No Other type discharge _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? __

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long?_____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) Straight/Heterosexual ( ) Lesbian/Gay/Homosexual ( ) Bisexual ( ) Transsexual

( ) Unsure/Questioning ( ) Asexual ( ) Other ( ) Prefer Not To Answer

What is your spouse or significant other's occupation?_____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many?_____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:_____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Legal History:
Have you ever been arrested?____
Do you have any pending legal problems?_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement?_____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

Signature:_____Date:_____

Guardian Signature (if under age 18):_____ Date: _____

Emergency Contact:_____Telephone Number:_____

For Office Use Only:

Reviewed by:_____Date: _____

Reviewed by:_____Date: _____