Breaking Free Counseling Services

CLIENT INFORMATION

(Please Print)

Client's Name: ____ DOB: _______/________/_______ Sex: M / F

Address: _____________________________________ City: _____________________ State: _______ Zip: _______________

SSN:____ Email: ____

☐ Check this box to be added to our mailing list. Your information will never be shared or sold.

Home Phone: _(_____________)______________________ Work Phone: _(____________)_________________________

Cell Phone: _(_____________)_________________________ Other Phone: _(____________)_________________________

Can we leave a message at home? ( ) Yes ( ) No At work? ( ) Yes ( ) No On cell? ( ) Yes ( ) No

Marital Status: ( ) Married ( ) Single ( ) Divorced Driver's License #: ____

Employer: ____________________________________ Address: ____

Name, Address, Phone Number of relative ***not*** living with you: ____

____

Relationship of above: ____

Any known allergies? ____

Current Medications: ____

Primary Care Physician's Name, Address and Phone Number: ____

____

Do you want to share information with your physician? ( ) Yes ( ) No

Is school board paying? ( ) Yes ( ) No If "no" continue to next section.

Primary Insured's Name: _____________________________________ DOB: ______/_______/______ Sex: M / F

Insured's SS#: _____________________________________ Relationship to Patient: __________________________________

Employer: ____ Insurance Company: _____________________________________

Address: ____

Group #: ___________________________________ Policy #: ____

"All appointments must be changed or cancelled 24 hours in advance to avoid a charge"

I understand and agree that (regardless of y insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to this information.

Release of Information: In order to process my claim, I hereby authorize release of any medical or other information necessary for this purpose only.

I hereby assign all medical, including Major Medical benefits to which I am entitled, to the above named provider.

Signature of Patient or Legal Guardian:____ Date: _______________________

Intake Questionnaire

Name: ____ Date: ______________________________

Prior to beginning therapy with me, I request that all of my clients complete this form. The questions are designed to help you clarify the changes you want to make in your life, and the expectations you have of the following counseling relationship. Please give me these questions much thought.

1. Make a list of things you want to change in your life:

   ____

   ____

   ____

   ____

   ____

Rewrite the above list from most important (#1) to least important (#12):

1. ______________________________________ 7. ______________________________________

2. ______________________________________ 8. ______________________________________

3. ______________________________________ 9. ______________________________________

4. ______________________________________ 10. ______________________________________

5. ______________________________________ 11. ______________________________________

6. ______________________________________ 12. ______________________________________

2. What are some of your self-defeating behaviors? That is, what do you do that seems to make things worse? (or just does not help you): ____

   ____

   ____

   ____

   ____

   ____

Breaking Free Counseling Services

Initial Intake

Client Name: ____ DOB: __________________________ Age: _________________
How did you hear about us? ______________________________________ Education: ______________________________
Problems with housing or daily living activities? (ie, transportation) ____
Legal Problems? ____
Financial Problems? ____

Family	Name	Age	Living / Deceased
Parents			
Spouse			
Children			
Siblings			

Please answer the following statements by how you feel:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with my life:	( )	( )	( )	( )	( )
I feel good about myself:	( )	( )	( )	( )	( )
I am happy with the way I look:	( )	( )	( )	( )	( )
I have a good relationship w/ my family:	( )	( )	( )	( )	( )
I have supportive friends:	( )	( )	( )	( )	( )
My health is good:	( )	( )	( )	( )	( )
I experience little physical pain:	( )	( )	( )	( )	( )
I have adequate physical strength:	( )	( )	( )	( )	( )
I enjoy my leisure time:	( )	( )	( )	( )	( )
I am happy with my job/work:	( )	( )	( )	( )	( )

The following items concerns feelings you may have had <u>during the last month.</u>

I have a feeling of hopelessness about the future:	( )	( )	( )	( )	( )
I feel worthless:	( )	( )	( )	( )	( )
I feel blue:	( )	( )	( )	( )	( )
I feel weak in parts of my body:	( )	( )	( )	( )	( )
My heart pounds and races:	( )	( )	( )	( )	( )
I have urges to beat, injure, or harm someone:	( )	( )	( )	( )	( )
I feel that I am watched or talked about by others:	( )	( )	( )	( )	( )
I have to avoid certain things, places or situations because they frighten me:	( )	( )	( )	( )	( )

The following items describe difficult or stressful situations you may have experienced <u>during the last month.</u>

I have recently had a physical fight with someone:	( )	( )	( )	( )	( )
I have recently tried to harm myself or had a plan to:	( )	( )	( )	( )	( )
I have recently become upset or angry:	( )	( )	( )	( )	( )
I have recently broken things or destroyed property:	( )	( )	( )	( )	( )
I am able to get around the community on my own:	( )	( )	( )	( )	( )
I can get help when I need it:	( )	( )	( )	( )	( )
I take care of my home and living space:	( )	( )	( )	( )	( )
I am functioning well at my work/school:	( )	( )	( )	( )	( )

Medical History

Name: ____ Age: ___________________ Sex: M / F

Family Physician: ____ Date of Last Physical: _______________________

Previous Hospitalizations:

Where (Hospital & City)	When	How Long	Reason

Are you presently taking any medications? ( ) Yes ( ) No
If "yes" please list names & how often you take them: ____
____

Please list any previous Psychological/Psychiatric treatment or counseling: ____
____

Females Only: Any discontinued pregnancies? ( ) Yes ( ) No If yes, how many? ____________________
Full term pregnancies? ( ) Yes ( ) No If yes, how many? ____________________

Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following? Check any that apply.

( ) Kidney Disease ( ) Tuberculosis ( ) Heart Disease ( ) Mental Illness
( ) Cancer ( ) Drug/Alcohol Abuse ( ) Tumors ( ) Epilepsy
( ) Diabetes ( ) Nervous Disorders

Please check any of the following of which you had in the past or are now experiencing:

Problem	Past	Present	Problem	Past	Present
Blurred Vision	( )	( )	Chest Pain	( )	( )
Double Vision	( )	( )	Blackouts	( )	( )
Severe Headaches	( )	( )	Seizures	( )	( )
Dizzy Spells	( )	( )	Hepatitis	( )	( )
Head Injury	( )	( )	Allergies	( )	( )
Vomited Blood	( )	( )	Pneumonia	( )	( )
Back Pain	( )	( )	Diabetes	( )	( )
Hearing Loss	( )	( )	Sleeping More	( )	( )
Mood Swings	( )	( )	Sleeping Less	( )	( )
Compulsions	( )	( )	Confusion	( )	( )
Excessive Blood Loss	( )	( )	Stomach Pains	( )	( )
Loss of Consciousness	( )	( )	Jaundice	( )	( )
Shortness of Breath	( )	( )	Blood in Bowel Movement	( )	( )
Heart Attacks	( )	( )	Tuberculosis	( )	( )
Smoker's Cough	( )	( )	Kidney/Urine Infection	( )	( )
Blood in Urine	( )	( )	Menstrual Difficulties	( )	( )
Swollen Ankles	( )	( )	Bruise Easily	( )	( )
Weakness in Arms & Legs	( )	( )	Venereal Disease	( )	( )
Reactions to Medications	( )	( )	Blood Transfusions	( )	( )
Broken Bones	( )	( )	Sinus/Frequent Colds	( )	( )
Weight Loss	( )	( )	Weight Gain	( )	( )
Appetite Changes	( )	( )	Drug/Alcohol Abuse	( )	( )

Problem	Past	Present	Problem	Past	Present
Irritability	( )	( )	Excessive Worries	( )	( )
Crying Spells	( )	( )	Fears or Phobias	( )	( )
Hallucinations	( )	( )	Difficulty Concentrating	( )	( )
Frequent Loss of Temper	( )	( )	Extreme Nervousness	( )	( )
Frequent Job Changes	( )	( )	Bedwetting past age 6	( )	( )
Fingernail Biting	( )	( )	Blaming Others Frequently	( )	( )
Lack of Self-Confidence	( )	( )	Low Self-Esteem	( )	( )
Indecisiveness	( )	( )	Sexual Problems	( )	( )
Extreme Loneliness	( )	( )	Frequent Accidents	( )	( )

Client Signature: ____ Date: ______________________________

PROGRAM RULES:

1. Breaking Free Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or “search and seizure” methods will be employed.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from client’s financial institution (ie, NSF fee from bank) there will be a $20 fee collected prior to the next appointment.
4. Client’s must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should client be under the influence of substances other than prescribed medication, the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon fee.
5. **Except in cases of emergency, cancelations <u>must be made 24 hours in advance;</u> failure to give 24 hour notice will be considered a “no show” and billed accordingly, ie, at the usual agreed upon fee.**

<u>Program Procedures:</u>

1. Client’s rights to confidentiality will be observed at all times, with the following exceptions:
   In case of probable imminent danger of self or others.
   In cases of child abuse, including sexual abuse.
   Communicable diseases must be reported by the counselor to the appropriate county health department.

Or

   When you, the client, request that we relesse information. Information is shared with the other entities (ie, doctors, insurance companies, etc.) when your requested by signing an authorization to release information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.
2. We reserve the right to release only a treatment summary instead of detailed case notes.
   2A. A minimum requirement of 72 hours is needed for medical records, once a written request is received.
3. The undersigned will neither individually or jointly involve the therapist or Breaking Free Services, Inc. (and it’s staff) in any litigation. The undersigned will neither request nor require that Breaking Free Services, Inc. or the therapist provide testimony in court. The reason for t6his is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purposes, the services of a person outside of Breaking Free Services, Inc. must enlisted.

<u>Counseling Recordings / Artwork:</u> The use of videotaping or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or therapist training purposes. Your confidentiality is protected and recordings are erased after every session unless your permission is given for another use. In the case of video or audio taping, you would be informed ahead of time and your written permission will be needed. The use of photography typically involves pictures of children’s [lay structures (ie, sand trays, building blocks, etc.) or pictures of the children with our therapy pet. Children are offered copies of the pictures and this often helps them extend the therapy program to home and school. Artwork is sometimes used for training purposes, but the child’s identity is protected. If you have any questions about this, please ask your therapist.

Hours of Operation By appointment. Currently nights and some weekends are available.

Afterhours Emergencies In the event of behavior health emergency, contact 911 or go to the nearest crisis center: The Harbor Behavioral Health Center

Payment of Fees or Service

1. We accept cash, check and all major credit cards. Insurance reimbursement is not available at this time.
2. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount.

Acknowledgement / Consent:

I authorize the Release of Medical Information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Breaking Free Services, Inc. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Breaking Free Services, Inc. of any changes to my insurance information, address, telephone number, and any relevant changes.

By signing this form, I am acknowledging receipt of a copy of this paper and agreement to the orientation terms and conditions as provided by Breaking Free Services, Inc.

____
(Print Client's Name)

______________________________ / /
(Client's Signature) (Date)

______________________________ / /
(Parent/Legal Guardian's Signature – if a minor) (Date)