Catalyst Counseling Associates

1320 Louisiana Avenue Suite A, Saint Cloud, Florida, 34769
Phone: 407-593-0122
Fax: 407-593-0081
Email: catalystcounselingassociates@gmail.com
Website: catalystcounselingassociates.com

Patient Information

Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____

Address: _____

City/State: _____

Zip Code: _____

How would you like your appointment reminders?

Mobile Phone: ( ) _____ - _____ Call ☐ Text ☐

Home Phone: ( ) _____ - _____ Call ☐ Text ☐

Birth Sex: Male ☐ Female ☐

Gender Identity: _____

Sexual Orientation: _____

Race: _____

Languages: _____

Marital Status: Married ☐ Single ☐ Other ☐

Emergency Conact Information

Name: _____

Address: _____

Mobile Phone: ( ) _____ - _____

Relationship to you: _____

Catalyst Counseling Associates offers a "Patient Portal" for the convenience of our clients to be able to request appointments, see appointment times, view statements, and easily access patient medical information. If you are interested in contiuning to have acess to this portal, please indicate your email below!

Email Address: _____

Insurance or EAP Information

Health Plan Primary: _____ Subscriber Name: _____

Relationship to Subscriber: _____ ID Number: _____

Group / Policy #: _____ Pre - Authorization #: _____

Employer(For Group Plan): _____ Number of Visits: _____

Will you be using insurance?

Please, circle below

Yes☐ No☐

If NO, please initial below to state that you understand that you will be paying a set cash rate that will NOT be billed to your insurance instead.

_____

Presenting Problem and Treatment Planning

Describe the problem that brought you here today:

_____

_____

_____

When did you first notice this problem?

_____

_____

_____

Current Symptoms Checklist: Check any symptoms that are present, circle for major symptoms)

☐ Depressed mood	☐ Excessive guilt	☐ Decrease need for sleep
☐ Unable to enjoy activities	☐ Fatigue	☐ Increased irritability
☐ Sleep pattern disturbance	☐ Increased libido	☐ Anxiety attacks
☐ Loss of interest	☐ Racing thoughts	☐ Crying spells
☐ Forgetfulness	☐ Impulsivity	☐ Hallucinations
☐ Change in appetite	☐ Excessive energy	Other:

List **ALL current prescriptions** including over-the-counter medications **AND** supplements:

_____

_____

_____

Allergies:

_____

Presenting Problem and Treatment Planning

Please, list **ALL past psychiatric medications**(If you have ever taken any, please indicate dosage and how helpful they were to you):

_____

_____

_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you did not want to live?

☐ Yes ☐ No

If you answered YES, please answer the following. If you answered 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? ☐ Yes ☐ No

When was the last time you had thoughts of dying? ☐ Yes ☐ No

Has anything happened recently to make you feel this way? ☐ Yes ☐ No

On a scale of 1 to 10, (ten being the strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? ☐ Yes ☐ No

Have you ever thought about how you would kill yourself? ☐ Yes ☐ No

Is the method you would use readily available? ☐ Yes ☐ No

Have you planned a time for this? ☐ Yes ☐ No

Is there anything that would stop you from killing yourself? ☐ Yes ☐ No

Do you feel hopeless and/or worthless? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

Do you have access to guns? ☐ Yes ☐ No

If yes, please explain.

_____

Presenting Problem and Treatment Planning

Which services below would you consider while working with Catalyst Counseling providers for your concerns?

Services will be offered on medical necessity in collaboration with your provider.

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Medication Services
- ☐ Chemical Dependency
- ☐ Autism Services
- ☐ PSR
- ☐ Trauma Services
- ☐ ADHD Services
- ☐ Culturally Specific

Other:

Describe any treatment you have tried for this problem or others

Type:	When (Start - Finish)	Where	Why
Outpatient counseling			
Medication			
Psychiatric hospitalization			
Drug/Alcohol treatment			
Self-help/ support groups			

PCP Name:_____ PCP Number:_____

Current Therapist/Counselor:_____

Current Therapist/Counselor Number:_____

PCP Release Form

Please check one of following:

☐ NO, I DO NOT give consent to Catalyst Counseling Associates to release information to my Primary Care Physician (PCP).

☐ YES, I give consent to Catalyst Counseling Associates to release information to the Primary Care Physician (PCP) named below
(By checking yes, the therapist will be allowed to communicate and share information with the named physician.)

If you checked YES, please complete the following:

I hereby give my informed consent for Catalyst Counseling Associates to (check all that apply) :

☐ Talk with my Physician

☐ Release documentation regarding my treatment at CCA

PCP Name:_____ PCP Number:( ) _____-_____

PCP Address:_____ PCP Fax:( ) _____-_____

Print Client Name:_____ Date of Birth: _____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other

If other, please explain: _____

Signature of Client or Parent/Guardian: _____ Date: _____

I understand that this authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization. My refusal to release records will not affect my ability to obtain treatment. If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be redisclosed.

Presenting Problem and Treatment Planning

Please, check if you have experienced any of the following types of trauma or loss.
Only fill out what you feel comfortable with filling out.

- ☐ Emotional Abuse
- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Loss of a Loved One
- ☐ Witnessed Death
- ☐ Human Trafficking
- ☐ Neglect
- ☐ Homelessness
- ☐ Crime Victim
- ☐ Parent Illness
- ☐ Gang Violence
- ☐ Other:
- ☐ Lived in a Foster Home
- ☐ Multiple Family Moves
- ☐ Violence in the Home
- ☐ Parent Substance Abuse
- ☐ Immigration Trauma

Substance Type:	Last 12 Months				Prior Use			
	YES	NO	Frequency	Amount	YES	NO	Frequency	Amount
Alcohol	☐	☐			☐	☐		
Caffeine	☐	☐			☐	☐		
Marijuana	☐	☐			☐	☐		
Tobacco	☐	☐			☐	☐		
Hallucinogens	☐	☐			☐	☐		
Inhalants	☐	☐			☐	☐		
Opioids	☐	☐			☐	☐		
Hypnotics	☐	☐			☐	☐		
Stimulants	☐	☐			☐	☐		

Family Psychiatric History

Please, check if ANYONE in your family has been diagnosed with or treated for:

- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Anger
- ☐ Suicide
- ☐ Schizophrenia
- ☐ PTSD
- ☐ Alcohol Abuse
- ☐ Substance Abuse
- ☐ Violence

Social / Cultural Information

Do you have challenges finding support? (from family, friends, etc.)? Yes☐ No☐ Not Sure☐

Are you experiencing any difficulties or concerns due to race, culture, sexual orientation, gender identity, age, or ethnic issues? Yes☐ No☐ Not Sure☐

If yes, please describe.

_____

_____

_____

Please, describe your spirituality, religion, or worldview:

_____

_____

_____

Please, list any special areas of interest or hobbies:

_____

_____

_____

Any additional information or concerns you feel your provider should know:

_____

_____

_____

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Acknowledgment of Informed Consent, Rights, & Responsibilities, Complaints Process, and Privacy Policies

Print Client Name: _____ Date of Birth: _____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other

If other, please explain: _____

Informed Consent

I have read and understand the risk and benefits related to treatment and evaluation at Catalyst Counseling Associates (Catalyst) (CCA). I consent to receive mental health services by Catalyst. Any questions I have regarding these have been answered. Initial: _____

Rights & Responsibilities and Complaint/Grievances

I have reviewed and understand my rights and responsibilities and the Complaint/Grievance process for services at Catalyst. This includes complaints, fees, no-shows/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions I have regarding these have been answered. Initial: _____

Notice of Privacy Practices (PHI) (HIPAA)

I have reviewed Catalyst's privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have received/or have declined a copy of these policies. I understand that Catalyst will share basic information with my primary care unless I ask to "restrict" this disclosure. Initial: _____

Financial

If I cancel within less than 24 hours or do not show for an appointment, I will pay $50.00 . I am the "Financial guarantor", meaning I will be responsible for payment of co-pays, co-insurance, deductibles, and fees for services not covered by a plan or EAP. I understand that if I need a letter or paperwork of any kind completed; there will be a charge. I understand that all paperwork can take up to two weeks to be completed. Initial: _____

Medication Management

If given a prescription for Narcotics from the psychiatrist, I understand that I will need to schedule a therapy session at least once a month with a licensed mental health counselor, registered mental health counselor intern, registered social worker intern or licensed social worker. Initial: _____

Signature of Client or Parent/Guardian: _____ Date: _____

For Office Use Only:

Reviewed By:_____