



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 Contact 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 continuing to have access 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Decrease need for sleep |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> 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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> ADHD Services |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Autism Services | <input type="checkbox"/> Culturally Specific |
| <input type="checkbox"/> Group Therapy | <input type="checkbox"/> PSR | Other: |
| <input type="checkbox"/> Medication Services | <input type="checkbox"/> Trauma Services | |

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: _____

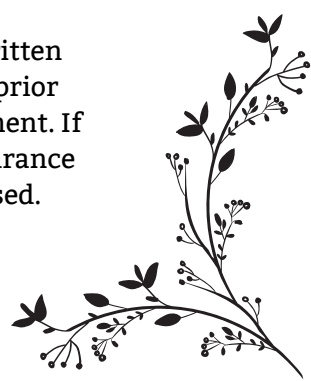
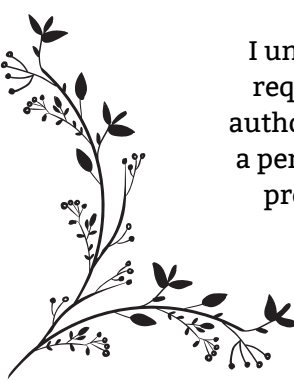
PCP Fax:() _____ - _____

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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Lived in a Foster Home |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Multiple Family Moves |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Crime Victim | <input type="checkbox"/> Violence in the Home |
| <input type="checkbox"/> Loss of a Loved One | <input type="checkbox"/> Parent Illness | <input type="checkbox"/> Parent Substance Abuse |
| <input type="checkbox"/> Witnessed Death | <input type="checkbox"/> Gang Violence | <input type="checkbox"/> Immigration Trauma |
| <input type="checkbox"/> Human Trafficking | <input type="checkbox"/> Other: | |

Substance Type:

Last 12 Months

Prior Use

| | Last 12 Months | | Prior Use | |
|---------------|----------------|----|-----------|--------|
| | 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:

- | | |
|---|--|
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> 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 \$35.00. 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: _____

