Serenity Counseling LCSW PLLC
20 Medford Avenue Suite 109
Patchogue, New York 11772
Phone 704-458-3025
fpredarrow1@gmail.com

INDIVIDUAL INTAKE AND TREATMENT PLANNING FORM

Informant/s: ________________ Others: specify: ______________ Therapist Name: ________________

Client's Name: ____________________DOB: ________ Age: ____ Sex: ______ Race: ______________

Date/Nature of First Telephone Contact: ____

____

____

____

Date of Initial Interview: _________Referral Source/consent to contact: __________________________

Sexual Orientation (if relevant)___________Education _____________Occupation_________________
Race______________ Ethnicity_________________ Religious Background: _____________________

Address: ___________________________________ City: ______________________ Zip: ___________
Social Security Number: ____________________________ School: _____________________________

Parent/Guardian 1 Name: ____________________ Address: ________________________________
Telephone: Home: __________________ Cell: ____________________Work: _________________
Drivers License #: ______________________ Email Address: ___________________________________

Parent/Guardian 2 Name: ____________________ Address: ________________________________
Telephone: Home: __________________ Cell: ____________________Work: _________________
Drivers License #: ______________________ Email Address: ___________________________________

Emergency Contact Name:_____________________ Relationship: ___________Telephone: ____________

Referred By: ____

Living Arrangements:

Marital Status: Married ___ Widowed ___ Divorced ___ Living Together ___ Separated ___ Single ___
If other please explain: ____
List Dates and Lengths of Previous Marriages: ____

Immediate Family Relationships: (Spouse, Children, Siblings, Parents)

Name	Relationship	Age	Location

Client Name: ___________________________________ Date: _______________________

INSURANCE

Check Type of Insurance: □ Private □ Medicare □ EAP □ None Insurance Company: ______________

Policy ID#: ____________________ Group #: _______________ Relationship to Insured: ___________

Policy Holder: ___________________ Insured's DOB: __________ Insured's SS#: _______________

EAP Name: ________________EAP Authorization #: _______________ EAP Phone #: _____________

FINANCIAL RESPONSIBILITIES (Please Initial)

Co-Payments are due at the time of service ________.

I hereby assign payment of insurance benefits directly to Serenity Counseling LCSW PLLC. While Serenity Counseling LCSW PLLC will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay _________.

It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges ________.

If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay your account or to arrange for a payment plan. If you do not respond you will be sent to collections _______.

While Serenity Counseling LCSW PLLC will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage _______.

I will be billed for phone consultations, letters and/or medical record copies at the therapists standard rate by 15 minute increments ________.

A 1% interest will be added to your portion of the bill that remains unpaid after 30 days ________.

Returned check fees $35.00 and the check amount ________.

You will be charged and personally responsible for the full cost of the appointment for missing an appointment without giving at least 24 hours prior notice to cancelling an appointment ________. Insurance companies do not pay for missed appointments.

I have received the treatment agreement and disclosure statement. I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges that my insurance company will not cover I am responsible for ___________.

To enable my therapist with accurate and confidential services please complete the following:

Please be aware that fax transmissions arrive at Serenity Counseling LCSW PLLC office and are distributed to the individual therapist. Confidentiality is maintained with these records, as with all records in our office ______.

Client Name: ______________________________ Date: ________________________

HIPPAA LAW: Notice of Privace Practice Achnowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to ...

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as but not limited to quality assessments and physician certifications.

I have received, red and understand the Notice of Privacy Practices containing more complete descriptions of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name (print): ______________________ Client Signature: ______________________

Parent/Guardian (print): ______________________ Parent/Guardian Signature: ______________________

HEALTH INFORMATION

Name of your Primary Care Physician: ______________________ May we contact? YES NO
Phone Number: __________ Address: ______________________ Date of last exam _____
I give consent or do not give consent (circle one) for my therapist, ____________to release my records to my primary physician to discuss my treatment,

______________________ ______________________ ______________
Print Name Signature Date

Are you receiving care by a Psychiatrist? Circle One Please **YES** **NO**
If yes, please enter Name and Phone Number: ______________________________

Relevant Medical History: (including all current medications prescribed, OTC and complementary, include dosage including psychotropic medications,; allergies, caffeine, tobacco, vitamins, any current health problems:

____

____

____

Past Psychiatric History (mental health and chemical dependency): hospitalizations (please explain)

____

____

____

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications:

____

____

Client Name: ______________________ Date: ______________

Chief Complaint and Present Illness (Please include descriptions of any symptoms)

Relevant Current and Historical Information/Precipitants

(Childhood/Developmental, marital and sexual, educational, work, socioeconomic, legal, criminal, other)

What goals/skills do you hope to gain?

Client Name: ______________________ Date: ______________________

Stregnths Assessment: Please check all items that you think apply to you

Trustworthy	Stable Employment	Kind	Religious/Spiritual Community
Good Sense of Humor/Fun	Flexible	Spontaneous	Open to Grow
Courageous	Forgiving	Physical Health	Creative
Exercises	Calm	Enjoys Learning	Resourceful
Happy Most of the Day	Good Communication Skills	Living for a Purpose	Living to the Fullest Potential
Family Support	Decisive	Organized	Participation in Hobbies
Confident	Financially Stable	Does Not Make Assumptions	Does Not Take Things Personally
Do Your Best Most of the Day	Friendly	Team Player	Relaxes
Eats Nutritional Foods	Articulate	Generous	Accepting

Needs Assessment: Please check individual items you want to address
Please circle the two most important

Marriage Concerns	Intimacy	Career/Job	Improve Communication Skills
Health Problems	Concentration	Bowel Trouble	Stomach Trouble
Self-Esteem	Hopelessness	Guilt	Sexual Difficulties
Temper	Depressed	Self-Control	Drug Use
Harm to Self	Finances	Impulsivity	Alcohol Use
Harm to Others	Antisocial Behavior	High Energy	Low Energy
Suicidal	Unhappy	Headaches	Lack of Focus
Lack of Motivation	Memory Impairment	Legal Matters	Anger
Sleep Problems	Repetitive Thoughts	Chest Pain	Abuse
Avoiding People	Nightmares	Trauma	Nervousness
Anxiety	Fears	Physical Fighting	Shyness
Meaningless	Crying Spells	Appetite/Weight	Unresolved Grief
Spiritual Concerns	Use of Time	Panic Attacks	Negative
Eating/Food/Hoarding	Stress	Infidelity/Affairs	Aggression
Jealousy	Divorce/Transition	Housing	Non-Compliance
Cyber Addiction	Disorientation	Elevated Mood	Withdrawing
Loneliness	Gambling	Hallucinations	Delusions
Heart Palpitations	Irritability	Judgement Errors	Phobias
Sexual Addiction	Often Sick	Trembling	Sleeping Difficulties
Disorganized Thoughts	Dizziness	Drug Dependency	Mood Shifts
Worry	Fatigue		
Other:			

Family History of Mental/Emotional Disturbance (including suicide, alcohol/substance abuse, physical/sexual abuse and domestic violence):

____
____
____
____
____
____
____
____
____

Client Name: ______________________ Date: ______________

DRUG AND ALCOHOL ASSESSMENT

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? (Please Circle) Yes No

If yes, self/other and their relationship to you: ______________________

Client Name: ______________________ Date: ______________________

Frequency of Alcohol Use:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Usual Alcohol Consumption:

_____Never _____1-2 drinks _____3-4 drinks per sitting _____5 or more drinks per sitting

Frequency of Use to Levels of Intoxication:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Self-Perception of Alcohol Use: (Check all that Apply):

___Occasional or Social ___Problem Use ___Psychological Dependence
___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program
___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

Please Describe any Drug and/or Alcohol-related Problems and history ex. legal, job, physical, or social):

____
____
____
____
____

Self Perception of Drug Use: (Check all that Apply)

___Occasional or Social ___Problem Use ___Psychological Dependence
___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program
___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

List a Community Resource You are Currently Benefitting from: ______________________

Have you ever thought you should cut down on your drinking?	**YES**	**NO**
Have you ever felt bad or guilty about your drinking?	**YES**	**NO**
Has anyone in your life asked you to cut down on your drinking?	**YES**	**NO**
Have people annoyed you by criticizing you of your drinking?	**YES**	**NO**
Does drug use impact your relationships or work functioning?	**YES**	**NO**
Do you use any kind of substance to deal with stress?	**YES**	**NO**

Alcohol/Substance Use, Abuse and Dependence history: ______________________

____
____
____
____

Client Name: ______________________ Date: ______________________

Risk Factors to Include Current or History of (Please circle all that apply):

Non-Compliance with Treatment
AMA/Elopement Potential
Prior Behavioral Health Inpatient Admissions
Domestic Violence
Child Abuse
Sexual Abuse
Eating Disorder
Suicidal/Homicidal
Other:

If yes to any of the above please explain giving current and historical information: ______________________

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Legal Information:

Do you have a probation officer or case worker? If yes, what is his/her Name, Phone number and Address:

____

Do you have an attorney? If yes, what is his/her Name, Phone number and Address:

____

Write 3 of your beliefs that Support your Life: ____

____

RISK ASSESSMENT (Please Circle)

Any Risk factors present? No Yes
If Yes, Specify and give details:
Current Risk factors:
- Potential for Violence:
- Hostile/Abusive behavior:
- Major Depression:
- Suicidal Ideation/Intent/Plan/Means/Attempt:
- Self Injurious behavior Ideation/Plan/Means/Attempt/Accomplished/Engaging in Currently:

Past Risk Factors:
- Suicide attempts:
- Violent behaviors:
- Inpatient Hospitalizations:
- Hostile/Abusive behavior:
- Major Depression:
- Suicidal Ideation/Intent/Plan/Means/Attempt:
- Self Injurious behavior Ideation/Plan/Means/Attempt/Accomplished/Engaging in Currently:

Risk Assessment (Type and degree of risk);

Signature of Understanding

Please sign below to indicate that "I have read the above policies and I understand and agree to comply with them. The information shared is true and accurate. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by a Serenity Counseling LCSW PLLC provider."

____

Print Name Date

____

Sign Name Date

DONOT COMPLETE BELOW

MENTAL STATUS EXAM **DATE:**_______________

APPEARANCE AND ATTITUDE (POSSIBLE DESCRIPTIONS: NEAT, UNKEMPT, BIZARRE, INAPPROPRIATE, EYE CONTACT, COOPERATIVE, GUARDED, SUBMISSIVE, UNCOOPERATIVE, PROVOCATIVE):

MOTOR ACTIVITY (NORMAL, HYPERACTIVE, AGITATED, RETARDED):

SPEECH (NORMAL, LOUD, SLURRED, STUTTERING, UNDERPRODUCTIVE):

AFFECT (APPROPRIATE, LABILE, EXPANSIVE, FULL RANGE, INAPPROPRIATE, CONSTRICTED, BLUNTED, FLAT):

MOOD (EUTHYMIC, DEPRESSED, ANXIOUS, EUPHORIC, ANGRY; *INCLUDE PATIENT'S SELF-REPORT ALSO*):

SLEEP DISTURBANCE (NONE, DIFFICULTY FALLING ASLEEP, EARLY AM AWAKENING, NIGHTMARES, HOURS SLEEP/NIGHT {CURRENT AND NORMAL}):

EATING DISTURBANCE (NONE, DECREASED APPETITE, WEIGHT LOSS {SPECIFY}, INCREASED APPETITE, WEIGHT GAIN {SPECIFY}:

SOMATIC COMPLAINTS (NONE, SEXUAL, MENSTRUAL, HEADACHES, FATIGUE, DIZZINESS, GASTROINTESTINAL/EXCRETORY):

SUICIDAL IDEATION: (NONE, CURRENT/PAST, PASSIVE WISHES TO DIE, IDEATION, INTENT, PLAN, COMMAND HALLUCINATIONS, PATIENT CONCERN ABOUT, *DESCRIBE IN DETAIL):*

HOMICIDAL IDEATION (NONE, CURRENT/PAST, IDEATION, INTENT, PLAN, VICTIM(S), PATIENT CONCERN ABOUT, *DESCRIBE IN DETAIL*):

THOUGHT PROCESS: (GOAL DIRECTED, CIRCUMSTANTIAL, FLIGHT OF IDEAS, LOOSENING OF ASSOCIATIONS, OBSESSIONAL):

PERCEPTUAL ABNORMALITY (NONE, DEPERSONALIZATION, DEREALIZATION, DEJA VU, ILLUSIONS, HALLUCINATIONS {AUDITORY, VISUAL, OLFACTORY},):

THOUGHT CONTENT ABNORMALITY: (NONE, OBSESSIONS, COMPULSIONS, PHOBIAS, MAGICAL THINKING, DELUSIONS {PERSECUTORY, GRANDIOSE, SOMATIC, BEING CONTROLLED, RELIGIOUS, THOUGHT INSERTION/DELETION, BIZARRE):

ORIENTATION (FULLY ORIENTED, DISORIENTED {ALWAYS, SOMETIMES: TIME, PLACE, PERSON}):

CONCENTRATION: (INTACT, IMPAIRED, E.G., SERIAL 7'S):

ATTENTION: (ALERT, DULL, VARIABLE):

MEMORY (INTACT, IMPAIRED {RECENT, PAST, REMOTE}):

DONOT COMPLETE BELOW

ESTIMATE OF INTELLIGENCE (BELOW AVERAGE, AVERAGE, ABOVE AVERAGE, SUPERIOR):

JUDGEMENT (INTACT, IMPAIRED {DAILY LIVING, INTERPERSONAL, DECISION-MAKING, IMPULSE CONTROL}, *SPECIFY DEGREE OF IMPAIRMENT* {MILD, MODERATE, SEVERE}):

INSIGHT: (INTACT, IMPAIRED {DOES NOT ADMIT PROBLEMS, BLAMES OTHERS} *DEGREE* {MILD, MODERATE, SEVERE}):

ADDITIONAL REMARKS ON MSE:

TREATMENT PLAN/CONSENT

DATE:____________________

DIAGNOSIS (DSM 5):

THERAPEUTIC GOALS (RESOLUTION OF PROBLEMS AND/OR SYMPTOMS, SHORT AND LONG TERM):

THERAPEUTIC TREATMENT PLAN:

MODALITY:

FREQUENCY:

ESTIMATED LENGTH OF TREATMENT:

TYPES OF INTERVENTIONS:

COLLATERALS INVOLVED:

REFERRALS:

____ PSYCHIATRIC/PHARMACOTHERAPY:
____ MEDICAL (SPECIFY):
____ COLLATERAL PROGRAM (E.G., AA, NA):
____ ADJUNCTIVE THERAPY (E.G., GROUP, FAMILY):
____ PSYCHOLOGICAL TESTING/ REFERRAL QUESTION(S):

PLANNED CONSULTATION/SUPERVISION:

THERAPY CONTRACT/INFORMED CONSENT DISCUSSION: (DATE, ANY PATIENT REACTION, COMMENTS)

____ HIPAA PRIVACY NOTICE/MEANS OF COMMUNICATION FORMS (DATE)

____ HIPAA AUTHORIZATIONS (FOR PLANNED REFERRALS/CONSULTATIONS) (DATES)

____ DIAGNOSIS

____ TREATMENT GOALS/PLAN

*****DONOT COMPLETE BELOW*****

____ BENEFITS AND RISKS:

____ ALTERNATIVES:

____ CONFIDENTIALITY AND ITS LIMITS (CHILD ABUSE/DUTY TO PROTECT/SAFE ACT):

____ FEE/FINANCIAL MATTERS (SPECIFY ARRANGEMENTS):

____ MANAGED CARE ISSUES:

____ CANCELLATION POLICY/SCHEDULING ISSUES (SPECIFY):

____ EMERGENCY AVAILABILITY (SPECIFY):

____ INDIVIDUAL CONCERNS OF PATIENT:

____ PROFESSIONAL QUALIFICATIONS/COMPLAINTS:

DONOT COMPLETE BELOW

Presenting Problems (Clinical Summary) (To be filled out by Clinician)

______Mental health/Symptoms
______Inerpersonal/Social
______Marital/Family
______Addictions
______Physical/Health
______Work
______School
______Other

Case Formulation (To be filled out by Clinician)

(Include etiology of problems such as internalized conflict, object relations disturbance, self/narcissistic, deficits in ego functioning, family system dysfunctions, negative thinking patterns, problem behaviors, cognitive/neuropsychological impairment, etc…)

FOR OFFICE USE ONLY

Disclosure Statement Signed- Yes No	Insurance Card Copied- Yes No
CCA Completed and signed- Yes No	Treatment Plan Completed and Signed- Yes No
Intake Paperwork with HIPAA and Minor Consent form Completed and Signed- Yes NO	Release Form to Speak with Physician Completed and Signed- Yes No N/A
Billing Diagnosis Is:	For Billing: Consumer is Entered into System- Yes No