ALTERNATIVES CENTER FOR COUNSELING AND PSYCHOTHERAPY
1699 E. Woodfield Rd., Suite 007
Schaumburg, IL 60173

DATE____________ THERAPIST________________

PATIENT INFORMATION:

NAME____AGE_____DOB_______SSN________________

ADDRESS__________________________CITY________________________STATE _____ZIP__________

HOME PHONE (___) _________________OK TO LEAVE MESSAGE Y / N_________________

WORK PHONE (___) _________________OK TO LEAVE MESSAGE Y / N_________________

PHYSICIAN____________________ PHONE (___) __________SPECIALTY_________________

MEDICAL CONDITIONS____

MEDICATIONS/DOSAGE_________________________________ MD PRESCRIBING__________________

PREVIOUS OUTPATIENT TREATMENT____

PREVIOUS INPATIENT TREATMENT____

WHO REFERRED YOU? ____

EMERGENCY CONTACT__________________RELATIONSHIP_________PHONE (___) ______________

INSURANCE INFORMATION:

INSURED'S NAME: ____________________________ INSURED'S EMPLOYER_______________________

INSURANCE CO. NAME_________________________________ INSURED'S DATE OF BIRTH ________________________

INSURANCE CO ADDRESS ______________________
____
____

INSURED'S SOC. SEC. # _________________
GROUP NAME__________________________
POLICY #______________________________

RELATIONSHIP TO INSURED: SELF WIFE HUSBAND CHILD OTHER

NAME OF PARENT OR GUARDIAN RESPONSIBLE FOR BILL
(IF OTHER THAN PATIENT)____

ADDRESS ___________________________ HOME PHONE: _________
___________________________ WORK PHONE: _________

I guarantee payment for services rendered to me.

_____________________________________ DATE_________

I authorize payment of medical services to undersigned physician or supplier for services described below.

_____________________________________ DATE_________

I authorize the release of any medical or service information necessary to process the claim for services rendered.

_____________________________________ DATE_________

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FOR OFFICE USE ONLY: DSMV/ICD10 ______________ ______________ ____________

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Therapy Information

Description of Treatment Offered

Psychotherapy (individual, family, or group) consists of discussions between the client(s) and the therapist that are designed to understand the client's immediate problems and symptoms and to develop a plan that will aid in resolving these problems. Psychotherapy has potential benefits (e.g. improvement in identified problem(s), increased skills that will assist in coping) and potential risks (e.g. experiencing strong emotions, changes in ways of relating, feeling worse before feeling better). Due to the variety of conditions that make therapy successful no guarantees of outcome can be made. Your therapist may also suggest or recommend that you be seen for a psychiatric evaluation or psychological testing if the therapist believes this will improve your progress in therapy. **Discuss with your therapist any questions about treatment that you have.**

Appointments and Fees

Appointments are scheduled by each individual therapist for specific dates and times. You must provide at least 24 hours notice of cancellation or **you will be billed for the full session fee** (insurance companies cannot be billed for late cancellation or missed appointments).

Your therapist will discuss the fee(s) for services during your first session. Payment in full, or the patient deductible/copayment, is due at the time of service (i.e. at each session).

Confidentiality

Your treatment is confidential within the limits prescribed by law. In general, no information will be released without your written consent. Relevant laws, however, require your therapist to contact others if you appear to be a danger to yourself or to someone else, if your therapist learns about child abuse/neglect, or if ordered by a court.

If you (client) are under 12 years of age, your therapist may discuss your treatment with your parent or legal guardian. If you are between 12 and 18 years of age, your therapist may discuss your case with your parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes **places you in danger** of harming yourself or others your therapist will help you to discuss this with your parent or legal guardian.

Your therapist may consult or review your case with other professionals to improve the quality of your treatment. Information may also be released to insurance companies or their agents (i.e. managed care) if you are using these benefits.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND DISCUSSED ANY QUESTIONS WITH MY THERAPIST. I MAY ALSO REQUEST A COPY OF THIS FORM.

Client (print name):________________________ Signature_____________________________

Parent Guardian: _________________________ Signature_____________________________

Therapist Name: __________________________ Signature_____________________________

Date: ____________________________________

Alternatives Center for Counseling and Psychotherapy
Notification to Patient of Desirability of

Conferring with Primary Care Physician

Pursuant to Illinois law, you are informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary care physician, I am choose to notify him or her that you are seeking mental health treatment unless you waive such notification. Please indicate your wishes:

____ My primary physician is___________________________
Address : ____
____
Phone ____

____ I agree to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing the bottom of this form which will serve as an Authorization to Release Information permitting you to communicate with my said physician and share and release information to him or her regarding my seeking or receiving mental health services with you.

____ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to notify him or her.

____ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

Date__________ Patient____

Parent/Guardian______________________________________

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ALTERNATIVES CENTER FOR COUNSELING AND PSYCHOTHERAPY
1699 E. Woodfield Rd., Suite 007
Schaumburg, IL 60173

Notification to Primary Physician of Patient
Receiving Mental Health Services

Dear Doctor,

Pursuant to Illinois law requiring clinicians inform their patient's primary care physician that a patient is receiving mental health services, I am notifying you that_______________________________ is seeking or receiving such service from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your records. I look forward to the opportunity to confer with you about this patient as the occasion or need arises. Please feel free to contact me with any questions or concerns that you may have.

Sincerely, _____________________________________

ALTERNATIVES CENTER FOR

COUNSELING & PSYCHOTHERAPY
1699 E. Woodfield Rd, Suite 007F
Schaumburg, IL 60173
(847) 370-1995

Notice of Privacy Practices

Patient Acknowledgement

Patient Name: ____________________

Date of Birth: ____________________

I have been offered a copy of this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I have had the opportunity to ask questions.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____________________

Date: ________________________

Signature of responsible person (in addition to the identified client) ____________________________________

Relationship to patient (if signed by a personal representative of patient):

____

Patient Information

PATIENT INFORMATION - PLEASE PRINT CLEARLY			
NAME (Last, First,)	SSN#	BIRTHDATE	SEX
ADDRESS	CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL
EMPLOYER	EMPLOYER ADDRESS		

RESPONSIBLE PARTY INFORMATION (If Different than above)			
NAME (Last, First,)	SSN#	BIRTHDATE	SEX
ADDRESS	CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL
EMPLOYER	RELATIONSHIP TO PATIENT		

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSUREDS DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

SECONDARY INSURANCE (If Applicable)		
NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSUREDS DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

I authorize the release of any medical or other information necessary to process claims, including information related to Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

______________________________ ______________________________

Signature **Date**

& Psychotherapy
Client Information

Client Name: ______________________________ ***Date:*** _______________________

Background Information:

Are you: ☐ Single ☐ Married ☐ In a committed relationship
☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed

Do you live: ☐ Alone ☐ With a roommate ☐ With my significant other/partner
☐ Parents ☐ At school ☐ With my family/spouse

In the last two weeks have you been (check all that relate to you):

Suicidal ☐ Homicidal ☐ Self-Harm ☐ Problems with Memory ☐ Problems Concentrating ☐

Please complete the rest of the questionnaire regarding any specific problems or symptoms that you have been experiencing. Feel free to add any comments as needed.

DIRECTIONS:

Read each of the numbered items. If you respond YES, complete the questions, otherwise, if you answer NO, skip to the next category (next numbered item). Thank you.

1. **Would you describe your mood as generally sad, down in the dumps or depressed?** **☐No ☐Yes**

If YES: For how long? ____________________________
Have you ever been treated for depression before? ☐No ☐Yes
Is your mood: ☐ sad ☐ anxious ☐ irritable ☐ Other: ________________
Have you experienced a significant change or loss within the past 12 months? ☐No ☐Yes
Have you ever experienced an episode like this before? ☐No ☐Yes
Do you have trouble being happy or enjoying life? ☐No ☐Yes
Have you experienced any weight loss or change in your appetite? ☐No ☐Yes
Do you have difficulty falling asleep or staying asleep? ☐No ☐Yes
Do you find yourself without energy or very fatigued? ☐No ☐Yes
Do you have feelings of worthlessness or guilt? ☐No ☐Yes
Do you have difficulty with concentration or indecisiveness? ☐No ☐Yes
Do you think about death or have suicidal thoughts currently? ☐No ☐Yes
Have you ever made a suicide attempt before? ☐No ☐Yes

2. **Would you describe your mood as euphoric, irritable, or beyond your normal?** **☐No ☐Yes**

If YES: For how long? _____________________________
Have you ever been treated for manic-depression before? ☐No ☐Yes
Have you ever experienced a manic episode before? ☐No ☐Yes
Have you ever experienced a depressed episode before? ☐No ☐Yes
Do your thoughts race? ☐No ☐Yes
Do you need less sleep than you usually do? ☐No ☐Yes
Do other people tell you that you talk too fast or they can't get a word in? ☐No ☐Yes
Are you more destructible or have trouble paying attention than usual? ☐No ☐Yes
Are you finding yourself more productive than usual? ☐No ☐Yes

Are you finding that you are more impulsive and/or making risky choices? ☐No ☐Yes

3. Do you experience episodes of anxiety, panic or fear in daily life? ☐No ☐Yes

If YES: For how long? ___________________________

Have you ever been treated for anxiety, panic or related problems? ☐No ☐Yes

Have you ever experienced an anxiety or panic attack? ☐No ☐Yes

Do you experience: ☐ racing heart ☐ sweating

☐ choking ☐ nausea ☐ fear of dying

☐ feel unreal ☐ faint or dizzy ☐ fear of going crazy

☐ shakiness ☐ chest pain ☐ fear of losing control

☐ shortness of breath

Do you have anxiety about being in or places where your departure might be difficult, embarrassing? ☐No ☐Yes

Do you change your plans or avoid situations or activities because of anxiety? ☐No ☐Yes

Do you worry about having an anxiety or panic attack? ☐No ☐Yes

Do you have fears about specific objects or situations? ☐No ☐Yes

Do you think your fear is excessive or unreasonable? ☐No ☐Yes

Do you worry about reactions of others or being humiliated in front of others? ☐No ☐Yes

Would you describe yourself as generally anxious or worried about a number of events or situations in your life? ☐No ☐Yes

Do you have other symptoms that also happen when you are anxious or worried? ☐No ☐Yes

4. Do you find yourself having recurrent thoughts or impulses that won't go away and/or repetitive behaviors or actions in response to your thoughts? ☐No ☐Yes

If YES: For how long? __________________________

Have you ever been treated for obsessional thinking or compulsive behaviors? ☐No ☐Yes

Do you have specific thoughts that recur, and won't go away? ☐No ☐Yes

Do you have specific behaviors that you have to do to manage the thoughts? ☐No ☐Yes

Do you experience significant fear or anxiety if these behaviors can't occur? ☐No ☐Yes

Do other people tell you that your thoughts or behaviors are strange or odd? ☐No ☐Yes

Do you wash your hands, or clean a great deal to manage? ☐No ☐Yes

Do you check things repeatedly as a behavior to manage the feelings? ☐No ☐Yes

Do you count things as a behavior to manage the feelings? ☐No ☐Yes

5. Have you experienced a traumatic event/events in your life, or been emotionally, sexually or physically abused? ☐No ☐Yes

If YES: Approximately, at what age or ages did this occur? ___________________

Do you experience recurrent or intrusive distressing thoughts about it? ☐No ☐Yes

Do you experience intense fear or helplessness when faced with situations that seem familiar or similar, even if they are not? ☐No ☐Yes

Do you ever feel like the events were happening again? ☐No ☐Yes

Do you seem to lose time or have unexplained periods of time? ☐No ☐Yes

Have you ever experienced flashbacks? ☐No ☐Yes

Do you experience emotional numbness and feeling disconnected? ☐No ☐Yes

Do you avoid things because they remind you of the traumatic events/situation? ☐No ☐Yes

Is it difficult for you to not be on guard or to experience feelings? ☐No ☐Yes

Are you always on guard for things to go wrong? ☐No ☐Yes

Are you afraid of getting into trouble? ☐No ☐Yes

Do you use food (starving, binging, purging) as a way to manage feelings? ☐No ☐Yes

Do you use alcohol or drugs as a way to manage feelings? ☐No ☐Yes

Do you ever self-injury (cut, burn, scratch, etc.) to manage feelings? ☐No ☐Yes

Have you been treated for an addictive problem or depression? ☐No ☐Yes

6. Have you been told that you are too thin, or have great fear of becoming fat? **☐No ☐Yes**

If YES: Have you ever been treated for anorexia before? ___________________________

Do you work to keep your weight low, or keep trying to lose more weight? ☐No ☐Yes
Has your period stopped? ☐No ☐Yes
Do you maintain a limited diet? ☐No ☐Yes
What do you restrict?
Do you exercise to manage your weight? ☐No ☐Yes
What do you do and how often?
Do you ever binge? ☐No ☐Yes
Do you use diuretics, laxatives or diet pills/products to maintain/lose weight? ☐No ☐Yes
Do you use alcohol or drugs as a way to manage feelings? ☐No ☐Yes
Do you ever self-injury (cut, burn, scratch, etc.) to manage feelings? ☐No ☐Yes
Have you been treated for an addictive problem or depression? ☐No ☐Yes

7. Do you have episodes of binge eating? **☐No ☐Yes**

If YES: Have you ever been treated for compulsive overeating or bulimia? _____________

Do you experience a feeling of being out of control with food? ☐No ☐Yes
Do you try to prevent weight gain afterwards? ☐No ☐Yes
Do you maintain a limited diet? ☐No ☐Yes
What do you restrict? ____
Do you exercise to manage your weight? ☐No ☐Yes
What do you do and how often? _______________________________
Do you use diuretics, laxatives or diet pills/products to maintain/lose weight? ☐No ☐Yes
Do you use alcohol or drugs as a way to manage feelings? ☐No ☐Yes
Do you ever self-injury (cut, burn, scratch, etc.) to manage feelings? ☐No ☐Yes
Have you been treated for an addictive problem or depression? ☐No ☐Yes

8. Do you gamble? **☐No ☐Yes**

9. Do you use alcohol? **☐No ☐Yes**
During an average week, how much alcohol do you consume? _____________
When was your last drink? ____
How much did you consume? ____
When was the last time you were under the influence? ___________________

10. Do you use street drugs, IV drugs or prescription drugs (beyond their prescribed use)? **☐No ☐Yes**
What do you use? ____
How much? ____
How often? ____
When was the last time you used? ____