Castillo Psychological, LLC

1605 S. Main St.
Las Cruces, NM 88005
Email: services@castillopsychological.com

Phone: 575-527-0614
Fax: 575-541-4062

INTAKE INFORMATION

Name_____________________________ Social Security #_________________________

Date of Birth_____________ Age______ Guardian (if applicable) ________________

Address____

City ___________________________State__________ Zip Code____________________

Home Phone_________________________ Cell_________________________________

Work Phone_________________________ Email_______________________________

Employer___________________________ School______________________________

Highest Level of Education: ____

Referral Source: ____

Emergency Contact (name & number) ____

Please check if a message can **NOT** be left at the following number:

Home phone___ Cell Phone___ Work phone___

Medical Information

Primary Physician _______________________ PCP Phone ______________________

Medication ____

Medical Concerns ____

FINANCIAL INFORMATION

Primary Insurance ____

Member ID #: _______________________ Group ID #: ___________________

Secondary Insurance____

Member ID #: _______________________ Group ID #: ____________________

Guardian and/or Policy Holder and relationship to client

____

Guardian/Policy Holder's Social Security Number: _______________________________

Guardian/Policy Holder's Date of Birth: __________________ _____________________

Consent to Bill Insurance:

1. I authorize use of this form to release information for all my insurance submissions.
2. I understand I am responsible for the full amount billed for services provided.
3. I understand I am expected to pay the deductible, co-pay or outstanding balance at the time of service.
4. I authorize direct payment from the insurance company to this provider.
5. I permit a copy of this authorization to be used in place of the original.

____ _________________

Responsible Party Signature Date

MISSED APPOINTMENT POLICY

1. After 3 missed appointments without 24-hour notification, Castillo Psychological has the opportunity to discontinue treatment services.
2. If you are not able to attend your appointment, notice to Castillo Psychological must occur 24 hours prior to the missed appointment.
3. If you arrive 15 minutes after your scheduled appointment, this does not allow ample time and the appointment will need to be rescheduled.

I have read and understand the above missed appointment policy and agree to follow the requirements.

____

Print Name

____________________________________ _______________

Client Signature Date

COLUMBIA-SUICIDE SEVERITY RATING SCALE
(C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

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RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

	Suicidal and Self-Injury Behavior (Past week)	
☐	Actual suicide attempt	☐ Lifetime
☐	Interrupted attempt	☐ Lifetime
☐	Aborted attempt	☐ Lifetime
☐	Other preparatory acts to kill self	☐ Lifetime
☐	Self-injury behavior w/o suicide intent	☐ Lifetime

	Suicide Ideation (Most Severe in Past Week)
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

	Activating Events (Recent)
☐	Recent loss or other significant negative event
	Describe:
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

	Treatment History
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Noncompliant with treatment
☐	Not receiving treatment

	Other Risk Factors
☐	

	Clinical Status (Recent)
☐	Hopelessness
☐	Helplessness*
☐	Feeling Trapped*
☐	Major depressive episode
☐	Mixed affective episode
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)

	Protective Factors (Recent)
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral, high spirituality
☐	Engaged in work or school
☐	Engaged with Phone Worker *

	Other Protective Factors
☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

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I have been provided a copy of the Information to New Clients, Mental Health Policies and Procedures, and Privacy Practices. I agree to participate in treatment with

_____Janette E. Castillo, PH.D.

_____Joe A. Castillo, LMSW

_____Jack Turney, LMSW

_____Brianna Kocon, LMHC

____ _______________
Signature of Client Date

<u>If the client is a minor</u>: I am the legal guardian/custodial parent of

__________________________ and give my permission to Janette Castillo, Ph.D. and therapists employed at Castillo Psychological, LLC to provide psychological or counseling services to my child.

____ _________________
Signature of Parent/Guardian Date