Advanced Social Care

Intake Form

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started we need to collect some general information from you.

Date Completed:_____

GENERAL INFORMATION

Patient First Name:	**Patient Last Name:**	
Patient Date of Birth:	**Gender:** ☐ M ☐ F **Race:**	
Name of Person completing form (if other than patient):		
Address:		
City:	**State:**	**Zip:**
Home #:	**Cell #:**	
Email:		

EMERGENCY CONTACT

First Name:	**Last Name:**
Phone:	**Relationship:**
Address:	
First Name:	**Last Name:**
Phone:	**Relationship:**
Address:	

INSURANCE INFORMATION

PRIMARY INSURANCE	Policy Holder:	
Policy Holder D.O.B. (mm/dd/yyyy)	Relationship:	
Policy Holder Address:		
City:	State:	Zip code:
Policy Number:	**Group Number:**	
SECONDARY INSURANCE	Policy Holder:	
Policy Holder D.O.B. (mm/dd/yyyy)	Relationship:	
Policy Holder Address:		
City:	State:	Zip code:
Policy Number:	**Group Number:**	

GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have below:

_____

_____

Are you on any medications for any general medical problems you may have? ☐ YES ☐ NO

Do you have any allergies to medications? ☐ YES ☐ NO

Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO If yes, when, and where?
Have you ever had outpatient treatment by a psychiatrist? ☐ YES ☐ NO If yes, when and by whom?
Have you ever received counseling or psychotherapy in the past? ☐ YES ☐ NO If yes, when and by whom?

Prior Outpatient Treatment? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

_____

Please list any additional notes that you think would be helpful for treatment below:

_____

_____

_____

_____

_____

SOCIO-ECONOMIC HISTORY

Living Situation: ☐ housing adequate ☐ homeless ☐ housing overcrowded ☐ dependent on others for housing ☐ housing dangerous/deteriorating ☐ living companions dysfunctional	**Social Support System:** ☐ supportive network ☐ few friends ☐ substance-use-based friends ☐ no friends ☐ distance from family of origin	**Financial Situation:** ☐ no current financial problems ☐ large indebtedness ☐ poverty or below-poverty income ☐ impulsive spending ☐ relationship conflicts over finances
Employment: ☐ employed and satisfied ☐ employed but dissatisfied ☐ unemployed ☐ coworker conflicts ☐ supervisor conflicts ☐ unstable work history disabled:	**Legal History:** ☐ no legal problems ☐ now on parole/probation ☐ arrest(s) not substance-related ☐ arrest(s) substance related ☐ court ordered this treatment ☐ jail/prison _____ time(s) total time served:	**Military History:** ☐ never in military ☐ served in military – no incident ☐ served in military – with incident ☐ currently serving in military ☐ honorable discharge ☐ other type of discharge:

Intake Form

Sexual History:	**Cultural/Spiritual/Recreational History:**
☐ straight/heterosexual orientation ☐ lesbian/gay/homosexual orientation ☐ bisexual orientation ☐ transsexual ☐ asexual ☐ unsure/questioning orientation currently	Cultural Identity (ethnicity, religion): _____ **Describe any cultural issues that contribute to current problem(s):** Currently active in community/recreational activities? ☐ Yes ☐ No Formerly active in community/recreational activities? ☐ Yes ☐ No Currently engage in hobbies. ☐ Yes ☐ No Currently participate in spiritual activities. ☐ Yes ☐ No
Relationship History and Current Family: ☐ married ☐ children living at home ☐ divorced ☐ children living elsewhere ☐ single ☐ widowed ☐ in a relationship	

First Name:	Last Name:

CONSENT FOR TREATMENT

You are about to take a very important step in your mental wellness plan, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions. We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____ (Initial) _____ (Date)

You are our client and have confidentially rights. Confidentiality does not apply under certain situation: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide, or other dangerous behavior, we will inform you. If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, clients that have not been seen in 3 months will be considered inactive. A new evaluation will be required for any inactive client to be seen.

_____ (Initial) _____ (Date)

I, _____(client), do hereby seek and consent to take part in the treatment provided by Advanced Social Care , LLC. If I am attending group services I also understand and consent that confidentiality still applies and that Advanced Social Care , LLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____ (Initial) _____ (Date)

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

_____ (Initial) _____ (Date)

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information

is intercepted, Advanced Social Care is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone:_____Email:_____

_____ (Initial) _____ (Date)

AUTHORIZATION AND RELEASE OF INFORMATION

CONSENT FOR RELEASE OF INFORMATION I hereby authorize Advanced Social Care ("the agency") to release/exchange information about any emergency care I need to receive, with the individuals listed on the front of this card, identified as my Emergency Contacts. I also authorize the Agency to release/exchange information with my insurance company and its service authorization vender(s) necessary to authorize and process service authorizations and payment claims. I understand my consent is ongoing until revoked by written notice.

ACKNOWLEDGEMENT OF PROVIDER CHOICE

I acknowledge that I have been educated about the choices of provider agencies that offer the services I am eligible for, and I have free chosen Advanced Social Care, Inc. without duress or coercion.

ACKNOWLEDGEMENT OF ORIENTAION TO SERVICES

I acknowledge I have been oriented to the services I will receive in an understandable manner. I acknowledge I have received Advanced Social Care, Inc.'s Consumer Handbook and have had the opportunity to ask questions.

_____

PERSON RECEIVING SERVICES SIGNATURE DATE

_____

LEGAL GUARDIAN SIGNATURE DATE

APPOINTMENT CANCELLATION AGREEMENT

Each meeting is another opportunity to help you confidently take charge and start living the life that's important to you. We understand things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, the office of Healing Minds requires **24 business hours notification (Monday through Friday 8:00 am to 5:00 pm).** Please understand that we set aside this time for you, and if you are unable to make it, we will have missed an opportunity to meet with another valuable client. This policy is in place to give the office enough time to schedule another client in that time slot. If you fail to cancel within the 48 hours prior to your appointment a **$60** fee will be

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above to the best of my ability.

_____

Client Name (please print) Date

_____

Client/Guardian Signature Date