INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____ _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg? □Yes □No

Cell/Other Phone: ( ) - May we leave a msg? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy?
□No
□Yes, at Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes
□No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

7. How often do you engage recreational drug use? ◻ Daily ◻ Weekly ◻ Monthly ◻ Rarely ◻ Never

8. Have you had suicidal thoughts recently?
◻ Frequently ◻ Sometimes ◻ Rarely ◻ Never

Have you had them in the past?
◻ Frequently ◻ Sometimes ◻ Rarely ◻ Never

9. Are you currently in a romantic relationship? ◻ No ◻ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no

Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	

Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

John A. Brooks II, PsyD, LPC

750 S. Monroe Street
Monroe, MI 48161
(734) 639-2262

CLIENT PERSONAL INFORMATION

Date _____

Name _____ Date of Birth _____
Address _____ SS# _____
City _____ State_____ Zip_____ Email _____
Home Phone _____ Occupation _____
Cell Phone _____ Employer _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____
Relationship to Client _____
Insured's Birthdate _____
S.S. # _____
Address_____
City_____ State_____
Zip_____
Home Phone( )_____
Cell Phone( )_____
Employer _____
Occupation _____
Insurance Company _____
Ins. Co. Phone # _____
Group # _____
Plan # _____
Contract # _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____
Relationship to Client _____
Insured's Birthdate _____
S.S. # _____
Address _____
City_____ State_____
Zip_____
Home Phone( )_____
Cell Phone ( )_____
Employer _____
Occupation _____
Insurance Company _____
Ins. Co. Phone # _____
Group # _____
Plan # _____
Contract # _____

DISCLOSURE STATEMENT

I understand that, John A. Brooks II, PsyD, LPC is a clinical psychologist in independent practice and is solely responsible for his practice. All matters including therapeutic issues, financial issues, etc. are the responsibility of the psychologist.

AUTHORIZATION AND RELEASE

I authorize and request my Insurance Company to pay directly to the provider.
I understand that my Insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
I authorize my doctor to act as my agent in helping to obtain payment from my Insurance Companies.
I authorize release of Information to all my Insurance Companies.
I permit a copy of this authorization to be used in place of the original.
I authorize use of this form on ALL my Insurance submissions.

NOTE

If unable to keep appointment, kindly give 24 hours notice. Otherwise a charge will be made for the time reserved, which will not be covered by your insurance company. A 30% fee will be added to all delinquent accounts that are turned over to an outside agency in an attempt to collect monies owed. Credit/debit cards are gladly accepted for payment, however a fee of 3.5% will be added to the amount charged.

X_____ Date _____

Thank you for filing out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

John A. Brooks II, Psy.D., LPC

Licensed Professional Counselor

750 S. Monroe Street
Monroe, MI 48161
(734) 639-2262

Consent for Services

I, _____, the undersigned: Initial

voluntarily consent to therapeutic services for myself and/or my family and understand that I am free to withdraw my consent and discontinue services at any time. _____

understand and have agreed to the fee policy established for the services provided for myself and/or other family members. _____

Financial Agreement

I understand that I am responsible for all fees for services, and agree to pay any fees not covered by my insurance. _____

I agree to pay these fees on the day services are rendered. _____

I understand that when payments are made with a credit or debit card, a 3.5% fee will be added to the amount charged. _____

I understand a LATE CANCEL (less than 24 hours notice of a cancellation) or a NO SHOW (no appearance for a scheduled appointment) that I will be subject to a $125.00 charge when either occurs, which will not be covered by insurance. _____

I understand there is a $25.00 service charge on all returned checks. _____

I understand that a 30% collection fee will be added to all delinquent accounts that are turned over to an outside agency in attempt to collect monies owed. _____

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature if Client is a minor Date

_____ _____
Witnessed by Date

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of client or client's representative Date

WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Notice of Privacy Practices Given – Client Unable to Sign
Notice of Privacy Practices Given – Client Declined to Sign
Notice of Privacy Practices and Acknowledgment Mailed to Client
Other Reason that Client Did Not Sign_____

_____ _____

Signature of Therapist Date

Notice of Privacy Practices
For the Practice of:

John A. Brooks II, Psy.D., LPC
Clinical Psychologist

Your medical/psychological information is personal. We are committed to protecting your personal information. We create a record of the care and services you receive. This record is needed to comply with legal requirements. This notice applies to all of the records generated in this practice by either this psychologist or by one of the office employees.

This office is required by law to:
1. Make sure that treatment information is kept private;
2. Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
3. Follow the terms of this notice.

How this Office May Use and Disclose Your Personal Information
All the ways we are permitted to use and disclose information about you fits into one of these general categories:

For Treatment. Information about you may be discussed with your physician with your signed consent or without your consent in a life-threatening emergency.

For Payment. We may use and disclose information about you so that the services you receive at this office may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to share a diagnosis or treatment plan so that your health plan will pay this psychologist or reimburse you for treatment.

For Phone Messages. We may have to contact you regarding emergency changes in appointments. In the event that we have to leave a message, the message will be to contact this office. If you do not want us to call your home/office or to leave a message, please submit this in writing to this psychologist. We will not be discussing any information about you or with you on a cell phone without your written permission. Pleased be advised that if you leave a message on our office answering machine, at (734) 639-2262, it may be heard by someone other than your psychologist.

As Required by Law. We may disclose information about you when required to do so by federal, state or local law. For example, we may be required by law to report child abuse and neglect and threats of harm to another person.

Right to an Accounting of Disclosure. You have a right to request an accounting of disclosures. This is a list of disclosures this office has made about your treatment information.
You must submit such a request in writing. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure we may make of your treatment information.

We are not required by law to agree with your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to this psychologist.

Right to Request Confidential Communications. You have a right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to this psychologist. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You may obtain a paper copy of this notice from this psychologist.

Revisions to this Notice
This psychologist reserves the right to revise this notice. Any revised Notice will be effective for the information we already have about you. A revised notice will be posted in this psychologist's office.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with this psychologist or with the Secretary of the Department of Health and Human Services.
This psychologist will not penalize you for filing a complaint.

Other Uses of Personal Information
Other uses and disclosures of information not covered by this Notice of Privacy Practices will be made only with written authorization. If you provide us with an authorization, you may revoke it in writing, at any time. If you revoke an authorization, we will no longer use or disclose information about you for the reasons covered in your authorization.

To Avert a Serious Threat to Health or Safety. We may use and disclose information about you when necessary to prevent a serious threat to you or for the safety of the public or another person. Any disclosure would be made only to a person able to help prevent that threat.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use information about you to defend this office or to respond to a court order signed by a judge.

Limits to Confidentiality. Paper copies of billing information are kept in a locked room that is accessible to other psychologists who share the office building. Billing information stored electronically is also available to other psychologists who share the office building. For a list of these other psychologists, please contact this psychologist.

Your Rights Regarding Your Personal Treatment Information
You have the following rights regarding your personal information:

Right to Inspect and Copy. You have the right to inspect and copy your treatment information with the exception of any psychotherapy notes.

To inspect and copy your treatment information, you must submit your request in writing to this psychologist. We may charge you a fee for the cost of copying, mailing and other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied that denial may be reviewed. For information regarding a review, please contact this psychologist.

Right to Amend. If you feel information we have about you is incorrect or incomplete, you may ask to amend that information.

A request for an amendment must be made in writing and submitted to this psychologist. You must provide in this request your reason for amendment.

Your request may be denied if it is not in writing or if you ask us to amend information that:

1. was not created by us;
2. is not part of the information kept in this office;
3. is not part of the information which you would be permitted to inspect or copy;
4. is accurate and complete.

John A. Brooks II, Psy.D., LPC

750 S. Monroe Street
Monroe, MI 48161
(734) 639-2262

Personal Disclosure Statement

Personal information

I received a Bachelor of Arts degree in Psychology and a Master of Arts degree in Counseling from Siena Heights University. I received a Doctorate Degree in Clinical Psychology, and a Specialist degree in Humanistic and Clinical Psychology from the Michigan School of Professional Psychology. I have a variety of experience working with a variety of clients in individual, family, and group settings.

Theoretical orientation

I believe counseling is most effective in a non-judgmental, confidential environment. I believe in a holistic approach to counseling, and it is my intent to assist the client to lead a more fulfilling life by exploring issues that may facilitate change. I follow a humanistic / existential approach to counseling and believe that through this approach clients are capable of reaching their full potential.

Confidentiality

It is my intention to develop a trusting relationship with my clients and therefore anything disclosed in session will be kept confidential. I am required by law to report to the proper authorities if you disclose that you are going to hurt yourself or someone else, or if I suspect that there is a possibility of child, elderly, or other abuse direct toward others. I also may be subpoenaed and required by law to disclose records or testify in a court of law.

Counseling sessions

Counseling sessions are between 45-50 minutes long and to keep other clients from waiting it is important to start and end on time. Please notify me 24 hours in advance if you need to change your appointment, otherwise you will be charged for the appointment, even if you do not attend. Fees will be charged on a sliding scale from $80.00-$120.00 per session.

I look forward to working with you on your goals and objectives that lead you to a more fulfilling life.

Michigan Department of Community Health
Health Regulatory Division
PO Box 30670
Lansing, MI 48909
(517) 373-9196