312 W. Millbrook Road, Suite 121● Raleigh NC, 27609 ● Office (919) 825-1339 ● Fax (919) 301-8957
Web address: www.livewellintlcenter.org

ADULT INTAKE FORM

Date of Birth: _____
Subscriber #: _____
Group # _____

IDENTIFYING INFORMATION :
Home Address: _____

Home Phone: Mobile Number: _____

Email Address: _____

PATIENT NAME AND IDENTIFYING INFORMATION:
Last Name _____ First Name _____ Middle Initial ____
Date of Birth _____/_____/_____ Age _____ Gender: Male _____ Female _____
Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____
Widowed _____Spouse" Name:_____ _ Age _____ Years Married _____
Names of Children and/or Step Children and ages:
_____
_____
Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other: _____
Emergency Contact: _____ Home Phone_____
Who referred you to Living Well International Center, PC or how did you hear about us?
_____

OCCUPATIONAL /EDUCATIONAL INFORMATION:
Occupation: _____ Employer: _____ How Long? _____
If Currently a Student: What school? _____ Field of Study? _____
Part time: _____ Full Time _____ Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4
Other: _____
Military Service (including branch of service and dates): _____

MENTAL HEALTH/BEHAVIORAL INFORMATION:
What concerns have led you to pursue counseling? _____

_____
_____
_____
_____

Where is this impacting you the most? Check all that apply: Home ____ Work ____ Marriage____

God_____ Other_____ When did this begin to be a problem for you? _____
Please rate the severity of your present concerns: Mild _____Moderate_____ Severe _____
What do you hope to gain from counseling?_____

Current Symptoms Checklist: (check any symptoms that you are currently experiencing or have experienced within the last 12 months)

( ) Depressed mood
( ) Racing thoughts
( ) Excessive worry
( ) Unable to enjoy activities
( ) Impulsivity
( ) Anxiety attacks
( ) Sleep pattern disturbance
( ) Increase risky behavior
( ) Avoidance
( ) Loss of interest
( ) Increased libido
( ) Hallucinations
( ) Concentration/forgetfulness
( ) Decrease need for sleep
( ) Suspiciousness
( ) Change in appetite
( ) Excessive energy
( ) Excessive guilt
( ) Increased irritability
( ) Fatigue
( ) Crying spells
( ) Other:

_____
_____
_____
_____

SUICIDE RISK ASSESSMENT:
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No. If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way _____
_____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ___
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

If other people are involved in your present problem, who are they and how could they help improve this situation? _____

_____
_____

MEDICAL/HEALTH INFORMATION:
How would you rate your current health? Excellent _____Good _____ Fair _____Poor _____
Date of last physical exam: _____ Physician: _____
Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems): Yes _____ No _____ if yes, please explain: _____
Describe any physical problem you or a member in your household have which require medical or physical care: _____
_____
_____
_____

Medications (Over the counter or Prescription)	**Dosage**	**Reason for Medication**	**Prescribing Physician**

Have you ever had surgery? If yes, for what reason _____

Are there chemical substance abuse issues in your family? Yes _____ No _____ Who? _____

If clean/sober, for what length of time? _____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____ No _____

If yes, for what specific reason and where? _____

Have you ever participated in counseling before? Yes _____ No _____ If so, when and

why?_____ Name of Therapist:_____

CONSENTS/RIGHTS INFORMATION:

I. Consent for Treatment

I hereby give my consent for Living Well International Center, PC, to provide mental health services to my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client: Date:

II. Financial Release

I further understand that Living Well International Center, PC may use confidential information about me to bill and be paid for services. I hereby consent Living Well International Center, PC, to release information to the billing agent and/or funding source (commercial insurance referring area program) and for (commercial insurance/the referring area program) to release information to Living Well International Center, PC, for this purpose. **Client's Initials** _____

Client Rights/Grievance Policies (**See Handout**)

I have received and had explained to me the Client Rights handout. Living Well International Center, PC gave me this handout and verbally explained my rights as a client.

Client: Date:

III. **Privacy Rights (See Handout)**

I have received and had explained to me the Privacy Rights handout. Living Well International Center, PC gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client: Date:

I understand that one of my rights as a person served by, Living Well International Center, PC is to be able to choose how I am contacted.

I ***do/do not*** *(circle one)* give permission for Living Well International Center, PC staff to contact me at work.

Furthermore, I ***do/do not*** *(circle one)* give permission for Living Well International Center, PC to leave voice messages for me at ***home/work/both/neither*** *(please circle one).*

Client: Date:

I, Living Well International Center, PC have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Legal Guardian of the client to be served.

Signature: Date:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

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

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client's Signature Date

Teletherapy Consent Form

I. Teletherapy is the delivery of psychological treatment and consultation provided through interactive internet technologies where the patient and the clinician are not in the same physical location.

II. Clients are expected to attend therapy sessions regularly and require a min 24 hours notice for cancellation and reschedule.

III. A lack of access to the information that might be achieved in a face to face visit but not in a teletherapy session may result in errors in psychological judgment.

IV. There might be a risk of deficiencies, delays or failures during the transfer of services due to electronic circumstances.

V. Teletherapy does not provide emergency service.

VI. All information provided will be held confidential and will not be disclosed without permission, except where disclosure is required by law. The electronic systems that are used throughout the service incorporate network and software security protocols (encryption) in order to protect the confidentiality of the patient information and data.

By signing below, you acknowledge that:

You have fully understood and accept the terms mentioned above

You authorize the release of any medical or other information necessary to process insurance claims

Name

_____ _____

First Name Last Name

Date

_____