Revisions Counseling Services

Intake form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: / \_ / Age: \_ Gender:

Marital Status:

* Never Married □ Domestic Partnership □ Married □ Separated
* Divorced □ Widowed

Please list any children/age:

Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: May we email you? □ Yes □ No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

* No
* Yes, previous therapist/practitioner:

Are you currently taking any prescription medication?

* Yes
* No

Please list:

Have you ever been prescribed psychiatric medication?

* Yes
* No

Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good Please list any specific health problems you are currently experiencing:

1. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good Please list any specific sleep problems you are currently experiencing:

1. How many times per week do you generally exercise?

What types of exercise to you participate in

1. Please list any difficulties you experience with your appetite or eating patterns
2. Are you currently experiencing overwhelming sadness, grief or depression?

* No
* Yes

If yes, for approximately how long?

1. Are you currently experiencing anxiety, panic attacks or have any phobias?

* No
* Yes

If yes, when did you begin experiencing this? \_

1. Are you currently experiencing any chronic pain?

* No
* Yes

If yes, please describe

1. Do you drink alcohol more than once a week? □ No □ Yes
2. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
   * Infrequently □ Never
3. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?

On a scale of 1-10, how would you rate your relationship?

1. What significant life changes or stressful events have you experienced recently:
2. Are you having suicidal thoughts?

* No
* Yes

1. Do you have a plan?

* No
* Yes

1. Have you attempted suicide in the past

* No
* Yes

1. Has anyone close to you ever attempted suicide?

* No
* Yes

Circle the description that best fits how feel:

Hopeless Helpless Alone Worthless A burden to others

1. What prevents you from following through on you plan?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation Do you enjoy your work? Is there anything stressful about your current work?

1. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
2. What do you consider to be some of your strengths?
3. What do you consider to be some of your weakness?
4. What would you like to accomplish out of your time in therapy?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Alcohol/Substance / Use History:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Frequency** | **Amount** | **First use** | **Last Use** | **Comments** |
| **Alcohol** |  |  |  |  |  |
| **Amphetamines** |  |  |  |  |  |
| **Cannabis** |  |  |  |  |  |
| **Cocaine** |  |  |  |  |  |
| **Hallucinogens** |  |  |  |  |  |
| **Inhalants** |  |  |  |  |  |
| **Opioids** |  |  |  |  |  |
| **Phencyclidine** |  |  |  |  |  |
| **Other** |  |  |  |  |  |

**Consequences of use (circle all that apply): Medical Legal Financial Personal Occupational**

**Describe:**

**Current Symptoms** (check all that apply):

**Physical:** Increased Tolerance Withdrawal Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cognitive:** Blackouts Impaired Judgement Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral:** Loss of control Risk Behavior Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment History** (include TX level, dates & duration):

**Treatment Providers’ Names /Contact Information:**

**Revisions Counseling Services, LLC**

**190 Lily Cache Lane**

**Bolingbrook, IL 60440**

**Phone: 630-481-6644 Fax: 630-708-7632**

#### INFORMED CONSENT

*Thank you for choosing Revisions Counseling Services, LLC. Today’s appointment will take approximately 45 – 55 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or* concerns, please ask and we will try our best to give you all the information you need. Regina Thomas, LCPC has earned a Master of Science Degree in Mental Health Counseling from Walden University. She is licensed by the State of Illinois as a Licensed Clinical Professional Counselor. She has over 18 years of clinical experience in treating adolescents, adults and families using individual and family therapy with a concentration in Substance Abuse and Grief Counseling. Regina Thomas practices standard Cognitive Behavioral therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS**: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Regina Thomas will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.*

***Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_***

**FINANCIAL/INSURANCE ISSUES:** *As a courtesy we will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $100.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Regina Thomas.*

***I have received a copy of my fee schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.* ***You may have a copy of this form if requested.***

## Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

**COORDINATION OF TREAMENT:***It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no inform will be shared.*

*\_\_\_\_***You may inform my physician(s) \_\_\_\_I decline to inform my physician**

**PHYSICIAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### CLINIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

**Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*May we contact you at home (circle one)* ***yes no****? May we contact you at work* ***yes no?*** *May we contact you by cell phone* ***yes no?*** *Where may we contact you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?*

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:** *I/We consent that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ maybe treated as a client by Regina Thomas. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.*

***Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_***

**-Revisions Counseling Services, LLC**

**Medical Release Form for Insurance Billing**

|  |
| --- |
| **Patient Information** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name:** | | | **DOB:** | |
| **Address:** | | | | |
| **City:** | **State:** | | | **Zip:** |
| **Phone:** | | **Email:** | | |
| **Emergency Contact (name and number):** | | | | |
| **Employer:** | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurance Information:** | | | |
| **Employer:**  **Insurance Company**: | | | |
| **Insurance Address:** | | | **Phone Number:** |
| **Member ID #:** | | **Group#:** | |
| **Deductible:** | **Amount of Deductible met:** | | |
| **Co-Pay:** |  | | |
| **Diagnosis:** | | | |

By signing below I agree that all of the information I have provided is true and I give permission to Revisions Counseling Services to release medical records to my insurance company for the purpose of receiving payment. Under the circumstance that my insurance company does not pay for my scheduled office visits I will be responsible for payment directly to my Therapist, Regina Thomas, LCPC at Revisions Counseling Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_/\_\_\_/\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_/\_\_\_/\_\_\_

Therapist Signature