CLIENT 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 thirty minutes prior to your appointment to complete the form in the office.

Readmit: _____ Yes _____ No Date: _____

Driver License #: _____

Social Security #:_____ Race: _____

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

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

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 message? □ Yes □ No

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

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

Veteran: _____ _____ No

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

Allergies: _____

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 in 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 thirty days to one year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Suicidal Thoughts □ No □ Yes

Suicide Attempt: □ No □ Yes

Family History of Suicide □ 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: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Alcohol/Substance Abuse: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____
Learning Disabilities: □ No □ Yes	_____
Trauma History: □ No □ Yes	_____
Suicide Attempts: □ No □ Yes	_____

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

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? _____

_____

_____

Emergency Information
In case of emergency, Contact:

Name (1) _____ Relationship _____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

E-mail:_____

May we leave a phone voice message □ No □ Yes at work □ No □ Yes

May we communicate by email □ No □ Yes

Name (2) _____ Relationship _____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

E-mail:_____

May we leave a phone voice message □ No □ Yes at work □ No □ Yes

May we communicate by email □ No □ Yes

Physician's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Psychiatrist's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Counselor's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

PO's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Insurance Information

Primary Insurance _____Secondary Insurance _____

Contract ID # _____ Contract ID # _____

Group ACCT # _____ Group ACCT # _____

Subscriber _____ Subscriber _____

Subscriber Date of Birth _____ Subcriber Date of Birth _____

Client's Relationship to Subscriber Client's Relationship to Subscriber

□ Self □ Spouse □ Child □ Other □ Self □ Spouse □ Child □ Other

Referred Source:

How did you hear of this office (or from whom)? _____

Address _____ City_____ State _____

Relationship to referral source: _____ Phone _____

MIND-SET SOLUTIONS INITIAL TREATMENT PLAN

CLIENT	
NAME:	
DOB:	**AGE:**
SSN #:	
INSURANCE PROVIDER:	
Member ID #:	
GROUP #:	

BRIEFLY DESCRIBE REASON FOR REFERRAL or VISIT

(e.g. infidelity, Frequent arguments, difficulty resolving problems, frequent misunderstandings, poor communication, or boundary violations)

BRIEFLY DESCRIBE PROBLEM/SYMPTONS

(e.g. not speaking, sleeplessness, yelling, slapping, or hitting, increased depression, anxiety, stress, or sadness)

BRIEFLY DESCRIBE YOUR DESIRED GOALS

(e.g. Enhance trust, develop a loving marriage and partnership, develop positive communication style)

CLIENT(s) /GUARDIAN SIGNATURES:	DATE:
CLINICIAN SIGNATURE:	DATE:

By signing this document you agree to allow this initial treatment plan agreement to serve as authorization for your initial treatment plan and verbal permission for the development of a modified master treatment plan based on assessment outcomes and ongoing issues presented during the course of your treatment while utilizing a telehealth platform.

2006 Modified 2020

MIND-SET SOLUTIONS

NO SHOW & CANCELLATION POLICY

When you schedule an appointment with at any **MIND-SET SOLUTIONS (MSS)** office that time is reserved just for you. That is why we require **24-hour advance notification of cancellation**. You may leave a message on our voicemail any day of the week. The time you called will be posted with the message. Should you fail to show for your scheduled appointment or cancel less than the required 24 hours in advance, you will be charged the fee of **$25** for missed sessions. If you are being seen for reduced fee and pay less than $25 per session, the fee will be your usual session charge. We appreciate the courtesy you extend to us by honoring this agreement. Please note that we **cannot** bill your insurance company for missed sessions or for late cancellations. You will not be scheduled for additional sessions by your therapist until the fee is paid.

If we are billing Medicaid, an Employee Assistance Program, or certain third parties, the $25 fee may not be applicable. In this case, after **two no shows** or cancellations within 24 hours of your appointment time, you will not be allowed to reschedule an appointment. You may be placed on a call- back list to be seen later or on a different date.

If you have **three no shows** or late cancellations within a calendar year, you may be discharged from services.

By signing this agreement, you are acknowledging that you understand the policies listed above and that you will abide by this agreement.

I, the undersigned, accept and agree to all the above terms during my treatment at **MIND-SET SOLUTIONS**.

_____

Printed Name of Client

_____ _____

Signature of Client Date

_____ _____

Signature of (MSS) Staff Date

MSS Initial Consent for Treatment
General Consent for Evaluation and Treatment

TO THE CLIENT: Welcome! At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluations necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended diagnostic procedure to be used. You may then decide whether to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary evaluations and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your counselor about the purpose, potential risks and benefits of any procedure recommend for you. If you have any concerns regarding any assessment tool or treatment recommend, we encourage you to ask questions.

I voluntarily request a counselor/therapist, or the designees as deemed necessary, to perform reasonable and necessary evaluations, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, treatments, or interventions are recommended, I will be asked to read and sign additional consent forms prior to the treatments(s) or procedure(s).

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

I acknowledge that not all services provided by **MIND-SET SOLUTIONS** are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the Health Center as an out-of-network provider, and/or my failure to provide my insurance card.

Authorization (PLEASE COMPLETE):

I authorize payment directly to **MIND-SET SOLUTIONS** for services for which the University Health Center accepts payment. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Client or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship Date

Notice of MIND-SET SOLUTIONS Privacy Practices

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is especially important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the state of Missouri to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice took effect on April 14, 2007 and will be in effect until we replace it. We have the right to change any of these privacy practices if those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at **MIND-SET SOLUTIONS.** These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third-party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization, it will only impact your health information from that point on.

Notice of MIND-SET SOLUTIONS Privacy Practices

7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that is necessary to respond to the emergency.

8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our organization's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date