**LILAC CITY COUNSELING, INC.**

163 Rochester Hill Road, Rochester, NH 03867

603-743-4004

**ADULT INTAKE QUESTIONNAIRE**

Your appointment is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE AND RETURN THIS FORM AT YOUR INITIAL APPOINTMENT. PLEASE CALL YOU INSURANCE COMPANY AUTHORIZATION IF NEEDED. PLEASE NOTE THAT CO-PAYS AND DEDUCTIBLES ARE EXPECTED AT DATE OF SERVICE – WE TAKE ONLY CHECKS AND CASH. THANK YOU.

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person/Relation to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your initial appointment with us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you being treated for any health problems? Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What medications do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What mental health treatment have you had in the past? Any hospitalizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any mental health visits in the last 12 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes? How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeine? How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use substances? How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the members of you family and any others in your home:

Name Age Relationship Occupation

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

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Please circle any of the following problems which pertain to you:

Nervousness/Worry Fears Shyness Depression

Sleep/Insomnia Memory Energy/Tiredness Concentration

Ambition Nightmares Motivation Suicidal Thoughts

Anger Stress Relaxation Headaches

Appetite Making Decisions Panic Episodes Attention

Inferiority Feelings Medical Conditions Acute/Chronic Pain Suicidal Attempts

Loneliness Friendships Career/Education Divorce

Children Work Issues Being a Parent Marriage/Relationship

Finances Drug Use Alcohol Use Sexual Problems

Sexual Abuse Eating Disorder Family Violence

**INFORMED CONSENT REGARDING TREATMENT AND CONSULTATIONS**

Although we cannot guarantee that it will be effective, psychotherapy can be beneficial to many people; we believe you may have positive outcomes from treatment. Benefits of therapy often include the reduction of feelings of distress, resolution of problems, and better relationships. We want you to know that therapy can have risks, including but not exclusive to: experiencing uncomfortable feelings, or recalling unpleasant life events, or facing unpleasant thoughts, or making major life decisions. These are often a natural part of therapy, and most therapy ends in the resolution of the difficulties which brought you to our office.

To maintain our commitment in providing you with quality treatment, we maintain our licensure requirements, including adhering to our code of ethics, and regularly attending continuing education courses. We meet weekly to consult on treatment cases. We ask your permission to discuss your case anonymously to plan and address treatment needs. At any time, you have the right to question the therapeutic process and to refuse any procedure or method. We are always available to discuss your treatment. In our waiting room, we have posted a Client’s Bill of Rights and a HIPPA notice; please read these and feel free to ask any questions. If you have any questions about your clinician’s knowledge, experience, credentials, skills, or licensure, please ask your clinician to provide that information to you.

**PERMISSION**: I give my permission and consent to Lilac City Counseling, Inc. to provide psychological treatment and/or assessments with me. I also give permission and consent to the professional staff of Lilac City Counseling, Inc. to anonymously consult about my case for treatment planning needs.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ETHICS AND CONFIDENTIALITY**

As licensed Psychologists and Clinical Social Workers, we uphold the principles of the American Psychological Association’s Ethical Principles of Psychologists and the National Association of Social Worker’s Code of Ethics. Copies of these ethics are available in the waiting room. Under these ethics, all professional clinicians must maintain professional boundaries with current and past clients at all times. Clinicians should not socialize or become friends with clients, and sexual contact between a clinician and a client is unethical and subject to disciplinary action. In case of clinician misconduct, please notify the New Hampshire Board of Psychologists, 121 South Fruit Street, Concord, NH 03301 or the New Hampshire Board of Mental Health Practice, 117 Pleasant Street, Concord, NH 03301.

Under New Hampshire statute, all communication between a therapist and a client is privileged and confidential. However, there are conditions when disclosure of privileged communications to the proper authorities is required. These conditions include: a) when there is abuse or neglect (physical, emotional, and/or sexual) of children or incapacitated adult, b) when a person is a danger to himself, c) when a person is a danger to another person – if a threat is made, the individual in danger and/or the police department must be notified, d) when a person makes threats against real property, and e) when a judge issues a specific court order for records. If you use managed care insurance, disclosure of treatment information is required by your insurance to secure coverage. For all insurance billing, we are required to send information electronically. We can’t guarantee the confidentiality of such communications once it leaves this office. If you do not want information sent electronically, please inform us at the beginning of treatment, so we can determine how best to proceed with your billing. We employ administrative staff who have access to information for scheduling and billing; all staff are trained to protect your confidentiality and will not release any information at any time outside the practice. The professional staff are committed to the ethical principles of confidentiality, and no material will be communicated without your knowledge and your written permission except in the above noted conditions and those outlined by the HIPPA form you will receive upon intake.

**COORDINATION OF TREATMENT**

New Hampshire Statute requires us to notify you of the following: To determine whether there may be a physical cause to your mental health condition, we ask you to consider having a physical examination if you haven’t had one in the last 6 months. If your physician indicates that there is a physical cause, we are required to consult quarterly with your physician regarding your treatment progress. Your permission will be obtained under this condition.

**AGREEMENT**: I have read and I understand the ethics, confidentiality and coordination of treatment requirements.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s relation to subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Deductible? \_\_\_\_ What is your Deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_ Has your Deductible been met? \_\_\_\_\_\_\_\_

Number of Sessions allowed per year: \_\_\_\_\_\_\_\_ Sessions Used this year: \_\_\_\_\_\_\_\_\_ Co-pay Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_

Managed Care Authorization Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Sessions Authorized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT OF FINANCIAL RESPONSIBILITY**

I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I certify that my insurance information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance information.

I have received a copy of the office’s policies on fees, billing and collections. I have read and understood these policies, and I agree to be seen under these conditions.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR CLIENTS USING INSURANCE BENEFITS**

Most mental health insurance policies, including most Anthem policies and Medicaid, can be classified as managed care insurance, which means that the insurance company may limit the number of sessions or the type of services which are covered. **It is your responsibility to know your insurance limits**. Some managed care insurance policies require that you obtain preapproval for mental health services.  **PRIOR TO YOUR INITIAL VISIT, please call your insurance company and obtain information about the limits of your insurance coverage and if you need PRE-AUTHORIZATION, please get it.**

Some insurance companies will initially authorize a certain number of sessions. Once those sessions have been used, in order to obtain authorization for additional sessions, we are required to complete forms from your insurance company where they ask for information about your symptoms, diagnosis and treatment plan. We will be happy to complete those forms for you. If your insurance company denies authorization for additional sessions, and if you and your clinician feel on-going treatment is needed, we will work with you to develop a payment plan should you desire to continue your treatment without insurance coverage. Treatment decisions are always made by consideration of your mental health needs.

**If you have managed care insurance, please complete the following:**

I authorize Lilac City Counseling, Inc. to release to my managed care insurance company information about my symptoms, diagnosis and treatment progress and plan. This release will only occur when completing a managed care treatment review form or conducting a telephone treatment review to obtain authorization for treatment sessions as outlined by my insurance coverage. I understand that I can review the information with my clinician prior to its release. My managed care insurance company is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your managed care insurance may request that your clinician coordinate your treatment with your primary care provider. Information about your symptoms, diagnosis and treatment plan will be shared with your primary care provider. If further contact beyond the initial information disclosure is needed, your clinician will discuss this with you. Please complete the attached Release of Information authorization. Thank you.

If you do not want to authorize your clinician to discuss your treatment with your primary care provider, please sign here: I do not authorize the Release of Information about my treatment to my primary care provider.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician: I have reviewed this intake with my client, and I have answered any questions or concerns that my client has regarding treatment, office policies and procedures.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_