**LILAC CITY COUNSELING, INC.**

163 Rochester Hill Road, Rochester, NH

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spiritual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Is it OK to leave a message on phone voice mail? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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 supplements and/or medications do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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? \_\_\_\_\_\_\_\_ If so, where and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of your Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the date of your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**FOR CLIENTS USING INSURANCE BENEFITS**

Some mental health insurance policies 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 if your insurance is a manage care policy and what are 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 fill in the authorization number and allowed sessions in the places outlined above.**

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 therapist 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 to obtain authorization for treatment sessions as outlined by my insurance coverage. I understand that I can review the information with my therapist prior to its release.

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

Your managed care insurance may request that your therapist 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 therapist will discuss this with you. Please complete the Release of Information authorization form and bring it with this intake to your first session.

If you do not want to authorize your therapist 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LILAC CITY COUNSELING, INC.**

163 Rochester Hill Road, Rochester, NH 03867

603-743-4004

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Client Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Authorization is hereby voluntarily granted to Lilac City Counseling, Inc. by the below signed client/guardian to exchange information with the following person or organization.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary Care Physician Office**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street City State Zip Telephone Fax

**METHOD FOR RELEASING:** (Check all that apply) 🞏 Oral 🞏 Written 🞏 Fax (fax cover sheet required) 🞏 Email (additional waiver required)

**INFORMATION TYPE**: The following checked items are being: 🞏 Released 🞏 Requested



🞏 Information regarding present psychological functioning

🞏 Medical information

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE OF THIS INFORMATION**:

🞏 Coordinate treatment with primary care physician

🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to limit the disclosure of information as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Release/Obtain alcohol & drug abuse information that is protected by Federal Confidentiality Rule (42CFR).& (NHRSA 141-F8)

🞏 YES I understand that I am not required to consent to the release of alcohol, drug and/or HIV information

🞏 YES 🞏 NO I give my consent to release/obtain drug and alcohol information

🞏 YES 🞏 NO I give my consent to release/obtain infectious disease information

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that I can revoke this authorization in writing at any time**, except to the extent that Lilac City Counseling, Inc. has already taken action on this authorization. If not revoked beforehand, this authorization shall expire as follows:

(Check one) 🞏 One year from date of signature below

🞏 Upon reaching: (Specific date, event or condition) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once the requested information is disclosed pursuant to this authorization, Lilac City Counseling, Inc. will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPPA).

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

Client Signature Date Witness Signature Date

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

Parent/Guardian Signature (If applicable) Date