The Counseling Center

REGISTRATION FORMS

Please have these forms COMPLETED prior to your first office visit or we will have to reschedule your appointment. USE BLACK INK ONLY.

Intake Questionnaire
Patient Information
No Show/Late Cancellation Policy
Minor Policy
Notice of Privacy Practice
Consent for Treatment
Release of Information
****Any other paperwork specifically included**

We at **The Counseling Center** wish to take a moment to welcome you to our office.

Thank you for selecting us as your mental health service centered home and we look forward to serving you. Our goal is to provide you with the best coordinated, highest quality care as well as a safe place for change and growth.

CLIENT INFORMATION

The Counseling Center employs Psychologists and Professional Counselors to provide behavioral health services to clients.

Discussions between you and your therapist are confidential. No information will be released without your signed consent, unless mandated by law. If you have questions regarding confidentiality, please feel free to discuss them with your therapist. If you are not comfortable bringing these issues directly to your therapist, you can speak with the Business Manager or the Clinical Supervisor.

APPOINTMENTS, CHARGES AND MESSAGES

You can make appointments by calling our office, Monday thru Thursday between 7am-5pm & Friday between 7am-3pm @ 541-928-2710. After hours, you may leave a confidential voice mail for business and non-urgent matters. Please call to **cancel** or **reschedule** your appointment and avoid a missed appointment charge (Refer to NO SHOW POLICY). Insurance companies **DO NOT** cover these charges; therefore, they're your responsibility.

IN THE CASE OF AN URGENT MATTER, YOU MAY GO TO YOUR HOSPITAL EMERGENCY ROOM OR CALL THE LOCAL CRISIS LINE @ 800-560-5535.

936 8th Avenue SW Albany, Oregon 97321
Phone: 541-928-2710 Fax: 541-928-4301
www.albanycounselors.com

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PATIENT INFORMATION

Name ☐ M ☐ F **Birthday** / / **Age:**
Last First Middle Month Day Year

Address: **Social Security #:**
Street / PO Box City State Zip Code

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Parent's Name (for Minors only): Email:
Name Phone Number

Employer: ( ) -
Name Address Phone

Emergency Contact:
Name Phone Number Relationship

INSURANCE INFORMATION

PRIMARY INSURANCE:
Name ID Number Group Number

Subscriber:
Name Phone Number Relationship to Patient

Address:
(If different than Patient's) City State Zip Code Social Security #

Birthday / / Employer:
Month Day Year

Primary Care Doctor: _____

SECONDARY INSURANCE:
Name ID Number Group Number

Subscriber:
Name Phone Number Relationship to Patient

Birthday: / / Employer:
Month Day Year

Are you using an EMPLOYEE ASSISTANCE PROGRAM (EAP) benefit? **Yes** ☐ **No** ☐

EAP Company
Name Authorization Number # of Sessions Approved

Our services are billed to your insurance as a courtesy, provided **ALL ACCURATE** information is given to us at the time of your appointment. No oral or written info given by an employee of The Counseling Center will create a warranty of any kind. Any outstanding accounts sent to collection will be assessed a **$60 fee**; returned checks will be assessed a **$25 fee**. Payment arrangements can be made with the business office. **ALL NO SHOW and LATE CANCELLATION** fees can be up to **$155** and are billed directly to the responsible party, **NOT** the insurance company. Accounts not paid within 30 days may be subject to a $15 service charge. Cancellations **must be made no later than 5:00 pm the BUSINESS DAY prior to the appointment.**

PRINT NAME: _____ DATE: _____

SIGNATURE: _____
Patient/Parent/Guardian/Responsible Party

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Release of Information

This is NOT a Records Release

Please complete sign and date this form if you would like to authorize anyone other than yourself for scheduling, billing or verbal communications with The Counseling Center or your Counselor.

(Client) I, _____ authorize and give my consent to

NAME/RELATIONSHIP_____

NAME/RELATIONSHIP_____

NAME/RELATIONSHIP_____

(Circle)

SCHEDULE	BILLING	VERBAL	OTHER: (specify)

____**PLEASE CHECK IF THERE IS NO ONE YOU WISH TO AUTHORIZE**

I also understand that I may revoke this release orally or in writing at any time, except for action already taken. This release will expire in 12 months from date signed or (90) days after last face to face contact, whichever is later unless another date is specified.

It is The Counseling Centers right and mandated responsibility to report at risk behavior for self-harm or harm to others.

Time limitation of release:_____

Signed_____Date_____

Signed_____Date_____

(Legal guardian if client is a minor or 13 or under)

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CONSENT FOR TREATMENT

I, _____ , voluntary agree to receive mental health
(CLIENT PRINTED NAME)
Services from any of the therapists at The Counseling Center to provide such care, treatment and/or services which are considered necessary and advisable.

I understand and agree that I will participate in the planning of treatment and/or services, and that I may stop treatment and/or services that I receive at any time.

In the event that my therapist is no longer practicing at your clinic I understand my records will remain at The Counseling Center until I authorize The Counseling Center in writing to deliver said records to a therapist of my choice.

By signing this consent form, I also acknowledge that I have read and I understand the terms contained herein.

I consent that The Counseling Center may communicate with me by mail, email, Internet Communication and /or by phone.

Client Signature: _____

Client Printed Name: _____

Parent/Guardian Signature: _____

Printed name of signee: _____

Date: _____

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NOTICE OF PRIVACY PRACTICE
CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize the Counseling Center to use and disclose the health and clinical information of:

(Client Name:)_____ for the purpose of Treatment, Payment, and Health Care Operations. The Counseling Center is not liable for any internet security breaches for online counseling.

Treatment: The Counseling Center will use your health care information to provide you with clinical services. We may disclose your information to office staff or other personnel who are involved in your treatment.

Payment: The Counseling Center may disclose your health information for the purpose of determining eligibility, billing, and receiving payment from you, your insurance company or a third party.

Health Care: The Counseling Center may use your health information for administrative and business purposes.

Internet Communications: The Counseling Center provides counseling via internet communication in special situations. The Counseling Center will provide services in a closed room with only the counselor present unless otherwise disclosed in advance. The client is responsible for protecting the clients' privacy at the client's location. The Counseling Center is not responsible for the protection of privacy at the client's location.

You have the right to review The Counseling Center's Privacy Policy for additional information about the uses and disclosures of information described in this document prior to signing consent.

I understand that I have the right to revoke this consent provided I do so in writing, except to the extent that The Counseling Center has already used or disclosed the information in reliance on this consent.

_____

Client Signature (or person authorized by law to act on behalf of the patient)

_____ _____

Printed Name **Date**

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NO SHOW/LATE CANCELLATION POLICY

Dear Client:

Any cancellation calls received after 5:00 pm the business day prior to your appointment will be considered a Late Cancellation. A **"No Show"** is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your record as a "No Show."

A charge of up to $155 may be assessed for each Late Cancellation or No Show of an appointment. This fee is billed directly to the responsible party, NOT the insurance company.

To cancel an appointment, call 541-928-2710. Please leave a voicemail if our office does not answer. All calls are confidential and time-stamped.

The No Show and Late Cancellation fees are the sole responsibility of the client and must be paid in full before the client's next appointment.

****Be aware that if we bill you for a Late Cancellation or a No Show fee, this may impact your ability to receive the care and service you require from your counselor.****

Thank you for helping The Counseling Center provide the quality care you deserve!

Signature _____

Print Name _____

Date _____

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ACKNOWLEDGMENT OF
OFFICE POLICY FOR MINORS 13 AND UNDER

For safety reasons, we always depend on parents/adults to properly supervise their child(ren) in our office.

All children 13 and under shall **not be left unattended** by their responsible parent, adult guardian or caregiver.

Adults who have brought in a child(ren) for counseling are required to remain **on the premises** and available to our staff while the child(ren) are in their counseling session.

Any other child/children not in session may not be left in our lobby unattended for any reason and should be attended to and adequately supervised by a parent, guardian or caregiver 18 years of age or older.

CLIENT NAME (please print): _____

Client Signature (Age 14 or older): _____

Parent/Guardian signature:
(If client is Age 13 or younger) _____

Parent/Guardian printed name: _____

Date: _____

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ADULT INTAKE QUESTIONNAIRE

INSTRUCTIONS:

Please fill out this form as completely as possible and answer all sections that apply.
If you have any questions, please feel free to give our office a call.

NOTICE:
It is of utmost importance that you bring your paperwork **signed, dated, and completed** during your scheduled first visit to our office.

Please be advised that without your new client paperwork we will need to reschedule your appointment at a later date and time. Thank you.

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Adult Intake Questionnaire

Name (first, middle, last): _____

Date of Birth: _____

Social Security Number: _____

Age: _____

Gender: ☐ Male ☐ Female

Preferred Language: _____

Status: ☐ Married ☐ Living as married ☐ Single ☐ Divorced ☐ Same Sex Couple

Race: _____

Religion: _____

Place of Evaluation: The Counseling Center ☐ Albany ☐ Newport

Date of Evaluation: _____

Referral Source: _____

Strengths, Abilities, and Interests (hobbies and leisure activities)

Reasons client is seeking help.

Problem Areas:

☐ Job ☐ Relationship issues ☐ Sexuality ☐ Financial
☐ Drug use ☐ Parenting/Family issues ☐ Alcohol use ☐ Recovery issues
☐ Recent loss or death ☐ Grief ☐ Self-esteem ☐ Other traumatic event(s)
☐ Sleep ☐ Chronic pain/illness ☐ Anger
☐ School (grades, teachers, peers, attendance, etc)
☐ Abuse issues (emotional, sexual, physical)

☐ Self-control (anger, sexual impulses, food, excessive spending)

☐ Appetite (lack of appetite, recent weight gain or loss)

☐ Eating Disorder (anorexia, bulimia, compulsive eating, binge eating)

☐ Emotions (mood swings, hard to control emotions, feeling overwhelmed)

☐ Thinking (disorganized or unwanted thoughts, memory loss, trouble making decisions, obsessive thoughts)

Other (please list)

1. _____

2. _____

3. _____

Current Symptoms:

☐ Heart Racing	☐ Trembling	☐ Difficulty breathing	☐ Cold sweats
☐ Diarrhea, Vomiting	☐ Compulsive behavior	☐ Excessive worrying	☐ Panic attacks
☐ Fear of leaving home	☐ Edgy, stressed	☐ Family history of anxiety/panic	
☐ Obsessive thoughts	☐ Obsessive fears		
☐ Fear of _____		☐ Sense of hopelessness	
☐ Low self-esteem	☐ Low energy, fatigue	☐ Excessive guilt	☐ Lack of motivation
☐ Loss of appetite	☐ Overeating	☐ Depressed, unhappy	
☐ Difficulty Concentration	☐ Suicidal thoughts	☐ Suicide attempts	☐ Sleep difficulty
☐ Memory Problems	☐ Bipolar disorder	☐ History of depression	
☐ Auditory Hallucinations	☐ Visual Hallucinations	☐ Doing things not remembered later	
☐ Abnormal body sensations	☐ Feelings others plotting against client		☐ Grandiose Plans
☐ Hyperactivity	☐ Seizures	☐ Feeling of not needing sleep	

Other Symptoms:

_____

_____

_____

Family of Origin Problems:

- ☐ Drug/alcohol problems
- ☐ Depression
- ☐ Anxiety
- ☐ Anger issues
- ☐ PTSD
- ☐ Bipolar disorder
- ☐ Personality disorder
- ☐ Suicide

Risk Assessment	
History of suicide attempts?	☐ No ☐ Yes - *If yes, explain (i.e. dates, triggering events, method, medical treatment, etc.):*
Current suicidal ideation, intent, plans, or access to means?	☐ No ☐ Yes - *If yes, explain:*
Past suicidal ideation; year. Was there intent or a plan?	
History of self-injurious behavior?	☐ No ☐ Yes - *If yes, explain (i.e. dates, triggering events, method, medical treatment, etc.):*
Danger to self (DTS) risk factors and protective factors	Risk Factors: ☐ Prior suicide attempts, aborted attempts, or self-injurious behavior ☐ Repeated attempts with increasing severity ☐ Stated plan with intent ☐ Access to means (i.e. firearms) ☐ Substance abuse (current/past) ☐ History of suicide in friend or family ☐ History of physical/sexual abuse ☐ Ongoing medical illness (i.e. pain, central nervous system disorders, terminal illness) ☐ Events leading to shame, humiliation, or despair (i.e. losses, financial, health) ☐ Extreme agitation or recent acts/threats of aggression ☐ Social isolation ☐ Impulsivity ☐ Insomnia ☐ Increased anxiety ☐ Lack of feelings ☐ Hopelessness ☐ Psychosis (hear voices, radio or TV telling you to do something, seeing things that are not there?) Protective Factors: ☐ Immediate supports ☐ Social supports ☐ Responsibility to children or pets ☐ Planning for the future ☐ Positive therapeutic relationships (including engagement with assessor) ☐ Ambivalence for living ☐ Core values/beliefs (including religious) ☐ Sense of purpose ☐ Ability to cope with stress/frustration tolerance
History of harming	☐ No ☐ Yes - *If yes, explain (i.e. dates, triggering events, method, remorse, etc.):*

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Risk Assessment	
others?	
Current homicidal	☐ No ☐ Yes - *If yes, explain:*
Most recent homicidal ideation? Was there intent or a plan?	
Danger to others (DTO) risk factors	Risk Factors: ☐ Prior acts of violence ☐ Fire setting ☐ Angry mood/agitation ☐ Arrests for violence ☐ Prior hospitalizations for dangerousness ☐ Access to means (i.e. weapons) ☐ Current or past substance abuse ☐ Psychosis (i.e. command AH) ☐ Physical abuse as a child ☐ Current psychosocial stressors
Was duty to warn completed?	☐ No ☐ Yes - *If yes, explain:*

Mental Health Treatment

Where	When	Reason/Diagnosis/Other pertinent info.

Current Medication

Mental Health medication	Dosage	Additional Information (Reason for medication, take as directed, not following directions)
Physical Health medications	**Dosage**	**Additional Information (Reason for medication, taken as directed, not following directions)**

Adverse reactions to past psychotropic meds ☐ Yes ☐ No

☐ Excessive energy ☐ Severe insomnia ☐ Agitation ☐ Irritability

☐ Talking too much ☐ Fatigue ☐ Headache ☐ Racing thoughts

Has any antidepressant ever worked at first, then stopped being effective? ☐ Yes ☐ No

List all vitamins and herbal supplements:

1. _____

2. _____

3. _____

Hours slept per night _____.

Problems going to sleep ☐ Yes ☐ No Wake early ☐ Yes ☐ No

Wake during the night ☐ Yes ☐ No Nap during the day ☐ Yes ☐ No

Exercise ☐ Yes ☐ NoType of exercise? _____

Medical History

Conditions		**Additional Information** (onset, treatment, etc.)
Diabetes?	☐ No ☐ Yes	
Heart Disease (high blood pressure, heart attacks, etc.)?	☐ No ☐ Yes - *If yes, what:*	
History of stroke?	☐ No ☐ Yes	
Lung disease (Asthma, COPD, Emphysema, etc)?	☐ No ☐ Yes - *If yes, what:*	
Seizures?	☐ No ☐ Yes	
Cancer?	☐ No ☐ Yes - *If yes, what type:*	
Liver/Kidney disease?	☐ No ☐ Yes	
Hepatitis?	☐ No ☐ Yes - *If yes, what type:*	
Thyroid disorder?	☐ No ☐ Yes - *If yes, what type:*	
HIV/AIDS?	☐ No ☐ Yes ☐ Deferred	
History of head trauma/loss of consciousness?	☐ No ☐ Yes	
Chronic pain?	☐ No ☐ Yes - *If yes, explain:*	
Any other health conditions/disabilities?		
Allergies (including medications)?	☐ No ☐ Yes - *If yes, explain:*	
Surgeries?	☐ No ☐ Yes - *If yes, explain:*	
Number of pregnancies and number of births?		
Difficulties because of		

medical issues? Any need for assistance?	

Developmental History

Did mother or father using drugs before client's birth?	☐ No ☐ Yes - *If yes, explain:*
Developed at the same rate as other children?	☐ No ☐ Yes - *If not met explain:*
Speech/language difficulties (i.e. hearing or speaking)?	☐ No ☐ Yes - *If yes, explain:*
Visual impairment?	☐ No ☐ Yes - *If yes, explain:*
Hearing impairment?	☐ No ☐ Yes - *If yes, explain:*
Motor skills impairment?	☐ No ☐ Yes - *If yes, explain:*
Cognitive impairment?	☐ No ☐ Yes - *If yes, explain:*
Deficits in social skills?	☐ No ☐ Yes - *If yes, explain:*
Immunizations?	☐ Current ☐ Not Current ☐ Unknown - *If not current, explain:*
Additional information:	

Social History

Describe childhood (caregiver, siblings, any significant events, etc.)?	
History of abuse (physical, emotional, or sexual) or neglect?	☐ No ☐ Yes *If yes, describe:*
Siblings (ages, describe their relationship with client, etc.)?	
Friends	☐ No ☐ Yes *If yes, describe quantity and quality:*
Positive support systems	☐ None ☐ Poor ☐ Adequate ☐ Exceptional
Ever witness either parent being abused	☐ No ☐ Yes

Education History

Highest level of education?	☐ Grade School ☐ Middle School ☐ High School ☐ 2 Year College Degree ☐ 4 Year College Degree ☐ Masters ☐ Doctorial
Special education?	☐ No ☐ Yes - *If yes, explain:*
	504 Plan? ☐ No ☐ Yes IEP? ☐ Learning Disability ☐ Emotional Disability
Additional information:	

Employment History

Currently employed?	☐ No ☐ Yes - *If yes, describe (type of work, PT or FT, etc.), If no describe the last job:*

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Work/volunteer history?	☐ No ☐ Yes
Gaps in employment?	☐ No ☐ Yes - If yes, describe.

Legal History

Criminal history (arrests, incarcerations, etc.)?	☐ No ☐ Yes - *If yes, explain:*
History of court ordered evaluations or treatment?	☐ No ☐ Yes - *If yes, explain:*
Other legal issues (guardianship, CPS involvement, etc.)?	☐ No ☐ Yes - *If yes, explain:*
Supervision	☐ No ☐ Yes if yes PO's name

Substance Abuse History

	☐ No ☐ Yes			
Type	**Heaviest Used**	**First Use**	**Last Use**	**History/pattern of use (type, amount, and frequency)**
Alcohol				
Caffeine				
Cannabis				
Cocaine				
Hallucinogens				
Inhalants				
Nicotine				
Opioids				
Phencyclidines				
Sedatives, Hypnotics, Anxiolytics				
Other				
Drug of choice?		☐ No ☐ Yes - *If yes, what:*		
Times quit for more than one month?				
History of substance abuse treatment?		☐ No ☐ Yes - *If yes, explain:*		
In treatment?		☐ No ☐ Yes		
What kind?		☐ Out Patient ☐ Intensive Out Patient ☐ Residential Facility ☐ Hospitalization		
Treatment – where & when				
Tobacco use?		☐ No ☐ Yes - *If yes, how much:*		
Impact of substance abuse		☐ Relationship ☐ Job ☐ School ☐ Family ☐ Other_____		

	☐ No ☐ Yes	
Additional information:		

Current Living Situation

Living arrangements	☐ Family ☐ Friend ☐ Shelter ☐ Street ☐ Car ☐ Own Home ☐ Rent
Live with	
Current living arrangement safe	☐ No ☐ Yes
Income level	☐ Less than $10k ☐ $10k-$30k ☐ $30k-$50k ☐ Over $50k
Get around	☐ Car ☐ Bus ☐ Foot ☐ Other_____

Activities of Daily Living

☐ **Denies all ADL issues**		
Type of Activity	Denied problems	Difficulty reported (please explain)
▪ Bathing	☐	☐
▪ Grooming/hygiene	☐	☐
▪ Feeding self	☐	☐
▪ Dressing self	☐	☐
▪ Mobility	☐	☐
▪ Housework	☐	☐
▪ Shopping	☐	☐
▪ Managing money	☐	☐
▪ Taking medication	☐	☐