Whitling Counseling and Consulting
3201 State Route 257, Suite 1
Seneca, PA 16346
Email: melissa@whitlingcounseling.com Phone: (814) 493-8497

Client Intake Form

Date: _____ Date of First Appt: _____
Name: _____ Date of Birth: _____
Address: _____
_____
Home Phone: _____ Is it OK to leave messages? _____
Cell Phone: _____ Is it OK to leave messages? _____
Work Phone: _____ Is it OK to leave messages? _____
SSN: _____ Gender: _____
Email: _____ Is it ok to message? _____
Referred By: _____
Brief Description of the Presenting Issue: _____
_____
Medications: _____

Insurance Information

Primary	Secondary
Name: _____	Name: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Copay: _____ Deductible:_____	Copay: _____ Deductible:_____

Subscriber Information

Are you the subscriber? _____ Name of the Employer:_____
Subscriber Name: _____ Date of Birth: _____
Relationship: _____ Address if different from the patient:
_____

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Confidential Intake Form

Personal Information

Name: _____ Date: _____ DOB: _____
Address: _____
Phone (home): _____ Phone (cell): _____
Phone (work): _____ Occupation: _____
Employer: _____
Education: _____
Primary Care Physician: _____
How did you find out about this private practice? _____

Current Presenting Problem

What problem brought you into treatment? _____
_____
When did it start? _____
List any stressors that may have triggered the concern. _____
_____

* Please complete the symptom checklist on page 4 *

Past Treatment History

Have you ever been treated for a mental, emotional or drug & alcohol problem? _____ (If yes, please provide details below).

Outpatient Treatment

Name of the Provider/Agency/Facility: _____
Address: _____
Dates of Treatment:_____

Name of the Provider/Agency/Facility: _____
Address: _____
Dates of Treatment:_____

Inpatient Treatment

Name of the Psychiatric Hospital/Facility: _____
Address: _____
Dates of Treatment:_____

Name of the Psychiatric Hospital/Facility: _____
Address: _____
Dates of Treatment:_____

Substance Abuse Treatment

Name of the Provider/Agency/Facility: _____
Address: _____
Dates of Treatment: _____
Did you receive Detox? _____ Outpatient Counseling? _____
Intensive Outpatient Counseling? _____ Inpatient? _____

Name of the Provider/Agency/Facility: _____
Address: _____
Dates of Treatment: _____
Did you receive Detox? _____ Outpatient Counseling? _____
Intensive Outpatient Counseling? _____ Inpatient? _____

Physical History

What medications are you currently taking? (Include over the counter, prescription and/or illegal drugs) _____

_____

_____

Why are you taking these medications? _____

_____

Allergies? _____

List any current medical problems: _____

_____

List any serious illnesses and/or hospitalizations in the last year: _____

_____

When was the last time you had an appointment with your PCP? _____

_____

What form of exercise do you get and how often? _____

_____

Hobbies: _____

Any recent weight changes? If yes, Lose__ Gain__ How much? _____

Do you have a good appetite? _____ Do you eat healthy? _____

How much caffeine (coffee, tea, cola, chocolate) do you consume daily?

_____

How much alcohol do you drink, what kind, and how often? _____

_____

Do you use tobacco products? _____ If yes, what kind? _____

Marriage/Significant Relationships

Previous Marriage/Significant Relationships:

Name of partner: _____ Date begun_____ Date ended_____

Name of partner: _____ Date begun_____ Date ended_____
Name of partner: _____ Date begun_____ Date ended_____

Current Marriage/Significant Relationship

Name of partner: _____ Date begun_____
How did you meet your current partner? _____
Do you have any significant struggles in her current relationship? ____
If yes, circle any if applicable (lack of communication, constant arguments, unfulfilled emotional needs, sexual dissatisfaction, financial disagreements, in-law issues, infidelity, domineering partner, suspicious partner, other _____)
Please list the names and ages of your children: _____
_____
_____

Family History
(Biological Parents, Siblings, Grandparents, Aunts, Uncles)

Have any of your family ever been treated for depression, anxiety, psychotic disorders or drug & alcohol related problems? _____
If yes, who and what were they treated for? _____
_____
_____
_____
Is your mother living or deceased?_____
If living, what is her current age? _____ Education in Years____
What is/was her occupation? _____
If deceased, what was her age at the time of death?_____
Cause of death?_____ Your age when she died? _____

Is your father living or deceased?_____
If living, what is his current age? _____ Education in Years____
What is/was his occupation? _____
If deceased, what was his age at the time of death?_____
Cause of death?_____ Your age when he died? _____
Please list your brothers and sisters, including names and ages.

_____
_____
_____
_____
_____
_____

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ADULT SYMPTOM CHECKLIST

Instructions: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below. Write in the column "rating" the number that best describes the degree of difficulty you have been experiencing in each area prior to this appointment.

1	No Difficulty
2	A Little
3	Moderate
4	Quite A Bit
5	Extreme

To what extent are you experiencing difficulty In the area of:	**Rating**	**How Long**
1. Managing day-to-day life	_____	_____
2. Household responsibilities	_____	_____
3. School	_____	_____
4. Work	_____	_____
5. Adjusting to major life stressors	_____	_____
6. Relationships with family members	_____	_____
7. Getting along with people outside of the family	_____	_____
8. Isolation or feelings of loneliness	_____	_____
9. Lack of self-confidence, feeling bad about yourself	_____	_____

10. Apathy, lack of interests in things	_____	_____
11. Depression, hopelessness	_____	_____
12. Suicidal feelings or behavior	_____	_____
13. Physical symptoms	_____	_____
14. Fear, anxiety or panic	_____	_____
15. Confusion, concentration, memory	_____	_____
16. Mood swings, unstable mood	_____	_____
17. Uncontrollable compulsive behavior	_____	_____
18. Drinking, taking illegal drugs, misusing drugs	_____	_____
19. Controlling temper outbursts of anger, Violence	_____	_____
20. Impulsive, illegal, or reckless behavior	_____	_____

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CHILD/ADOLESCENT SYMPTOM CHECKLIST

Instructions: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below. Write in the column "rating" the number that best describes the degree of difficulty you have been experiencing in each area prior to this appointment.

1	No Difficulty
2	A Little
3	Moderate
4	Quite A Bit
5	Extreme

To what extent are you experiencing difficulty In the area of:	**Rating**	**How Long**
"Arguing"/Talking Back	_____	_____
Bullies/Intimidates Others	_____	_____
Cruel To Animals	_____	_____
Persistent Rule Breaking Behaviors	_____	_____
Conflicts with Authority Figures	_____	_____
Cries easily	_____	_____
Difficulties with changes in the family	_____	_____
Developmental Delays	_____	_____
Distractible/Inattentive/Poor Concentration	_____	_____
Drug and/or Alcohol Abuse	_____	_____

Eating Issues-Significant wt gain or loss	_____	_____
Emotional Dysregulation/Rages	_____	_____
Failing Grades in School	_____	_____
Fearful	_____	_____
Fighting/Hitting/Violence/Aggression	_____	_____
Fire Setting	_____	_____
Immature/Plays with Younger Children	_____	_____
Interrupts/Talks Out	_____	_____
Legal Issues/Breaking the Law	_____	_____
Likes to be alone/Withdrawn	_____	_____
Lying	_____	_____
Low Frustration Tolerance	_____	_____
Nail Biting/Skin Picking	_____	_____
Overactive/Restless/Hyperactive	_____	_____
Oppositional/Refuses to Follow Directives	_____	_____
Relationships with Siblings/Peers - Poor	_____	_____
Rocking and/or Other Repetitive Behaviors	_____	_____
Running Away Behaviors	_____	_____
Sad/Unhappy	_____	_____
Self-Harm Behaviors	_____	_____
Sexual Behaviors (Inappropriate for Age)	_____	_____
Suicidal Ideations/Attempts	_____	_____
Temper Tantrums	_____	_____
Thumb/Finger Sucking/Hair Chewing	_____	_____
Tics-involuntary movements/noises	_____	_____
Teased/victimized/bullied	_____	_____
Truant/Avoiding School	_____	_____
Wetting the bed/soiling undergarments	__kl;_____	

_____

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Notice of Privacy Practices

State and Federal laws require me to maintain the privacy of your health information and to inform you about the privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice will take effect on January 1, 2021 and will remain in effect until it is amended or replaced by myself.

It is my right to change the privacy practices provided the law permits the changes. Before I make a significant change, this Notice will be amended to reflect the changes and I will make the new Notice available upon request. I reserve the right to make any changes in the privacy practices and the terms of the Notice effective for all health information maintained, created, and/or received by myself before the date changes were made. You may request a copy of the Privacy Notice at any time by contacting myself, the Privacy Officer.

Typical Uses and Disclosures of Health Information

Your health information will be kept confidential, using it only for the following purposes:

Treatment: I may use your health information to provide you with professional services. I have established "minimum necessary or need to

know" standards that limit others (billing staff) from accessing your health information according to their primary job functions.

Disclosures: I may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to family, friends, and/or other people you choose to involve in your care. This will only occur if you consent that I may do so. I will also need consent or authorization before releasing your psychotherapy notes. "Psychotherapy Notes" are notes I have made following a session. This can include individual, group, joint or family counseling sessions. These notes are given a greater degree of protection than Protected Health Insurance.

Revocation: You may revoke such authorization of Protected Health Information or Psychotherapy Notes at any time, provided each revocation is in writing.

Payment: We may use and disclose your health information to seek payment for services provided to you and/or your family. The disclosure involves my billing specialist staff and may include insurance companies. The billing specialist/clerical person may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: I may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of an emergency involving your care, your location, and your general condition. If at all possible we will provide you with an opportunity to object to this use of disclosure. Under emergency

conditions or if you are incapacitated, I will use my professional judgment to disclose only that information directly relevant to your care.

Required by Law: I will use and disclose your health information when I am required to do so by law (court orders, discovery request or other lawful process). I will use and disclose medical information when requested by national security. If you are involved in a court proceeding and a request is made about the professional services I provided to you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or court order. The privilege does not apply when you are court ordered to treatment.

Serious Threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, we must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the **threat** or intent.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others. Abuse or neglect of a minor child will require myself to release health information without consent.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If

the information is required for lawful intelligence, counterintelligence or other national security activities, I may disclose it to authorized federal officials.

Appointment Reminders: I may use and disclose health information to contact you as a reminder that you have an appointment for treatment. If you do not wish to be contacted via telephone, please inform me.

Your Privacy Rights As A Patient

Access: You have the right to inspect and copy your medical information that may be used to make decisions about your care. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and health information that is subject to a law that prohibits access to health information. You must request to inspect and/or obtain a copy of your health record in writing. If you request a copy of your health care information or if you agree to a summary of such information, you will be charged a fee for this service. Your request may be denied under very limited circumstances. Depending on the circumstances, a decision to deny access may be reviewable and you may request that the denial be discussed in more detail.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied. For example we may deny your request if the information was not created by this therapist.

Restrictions: You have the right to request a restriction on certain uses and disclosures of your information. I am not required by law to agree to your request. If we do agree, I will comply with your request unless the information is needed to provide you with emergency care or other emergent circumstances.

Questions And Complaints

You have the right to file a complaint if you feel I have not complied with the Privacy Policies. Your complaint will be addressed with this therapist. If you feel I have violated your privacy rights, or if you disagree with a decision made regarding access to your health information, you can put your concerns in writing. We will then arrange a time to discuss this matter, in person, if possible with the hopes of finding a peaceful resolution. I support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with myself or the U.S. Department of Health and Human Services.

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Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: _____

Whitling Counseling and Consulting is required to provide you with a copy of the *Notice of Privacy Practice,* which states how I may use/or disclose your health information. Please sign this form to acknowledge receipt of a copy of the *Notice of Privacy Practice.* You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's *Notice of Privacy Practices.*

Signature of Client: _____Date:_____

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Therapist: _____Date: _____

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Statement of Client Rights & Responsibilities

Client Rights

- I have the right to receive information about my treatment provider, and treatment goals.
- I have the right to be treated with dignity and respect.
- I have the right to privacy and confidentiality.
- I have the right to fair treatment. This is regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- I have the right to the rights and privileges granted by State and Federal Law.
- I have the right to participate with my therapist in decision-making regarding treatment planning.
- I have the right to voice a complaint or appeal should a dispute arise over treatment or claims.

Client Responsibilities

- I have the responsibility to provide, to the best extent possible, information that my therapist needs in order to provide professional treatment to me.
- I have the responsibility to participate, to the degree possible, in understanding my mental health presenting issue and in the development of mutually agreed-upon treatment goals.

- I have the responsibility to inform the therapist of changes in my address and/or insurance coverage.
- I have the responsibility to keep scheduled appointments. I will contact my therapist within 24 hours as a part of the cancellation policy.

Client Signature: _____ Date:_____

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____

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Service Agreement & Consent to Treatment

Welcome to Whitling Counseling and Consulting. This agreement provides those who seek treatment and/or consultation services with a clear understanding of how this private practice is managed. I hope this information will help you understand the nature of the services. This document is intended to provide you with enough information to make an informed consent to participate in treatment. Please read this carefully and do not hesitate to discuss your questions or concerns about this information with myself.

Assessment: The initial stage of treatment is designed to help me understand your expressed need for services. I will gather historical information to help to learn about your situation and determine what treatment intervention would be helpful. By the end of the evaluation, which will last from 2 to 4 sessions, I will be able to offer you some initial impressions of your situation and discuss an initial treatment plan. You are encouraged to be actively involved in the development of treatment goals.

Treatment: Once treatment goals are identified, I will begin to work with you to help you improve your situation. The treatment process is most effective with healthy communication between patients and their providers. I will commit to offering patients the most professional services.

If a patient needs a higher level of care, I will work closely with the individual and/or family to refer them to a more appropriate treatment program and/or facility.

Services Offered: You will be offered services specifically designed for you presenting issues. These may include individual, marital, and/or family therapy. If it is determined you may benefit from the addition of medications, a referral to your PCP and/or a Psychiatrist may be recommended. It is your right to accept or decline this recommendation. A release of information will need to be signed prior to any consultations with medical doctors and/or psychiatrists.

Appointments: Barring any emergencies, you will be seen at the time of your scheduled appointment. Please note, most insurance companies consider 50 minutes a clinical hour. This allows for therapists to complete a psychotherapy note in between sessions. If you need to cancel your scheduled appointment, please cancel within 24 hours. With three or more no show appointments and/or late cancellations, you can be discharged from services.

Office Hours: I will be available the following hours:
Mondays 11:00am - 6:00pm, Tuesdays 11:00 am - 6:00pm,
Wednesdays 9:00am - 4:00pm and Thursdays 12:00pm - 7:00pm.

Mental Health Emergency Calls: If you are experiencing a mental health emergency and are experiencing suicidal and/or homicidal ideations/thoughts/plan etc., immediately report to the local emergency room for a mental health evaluation. You can also contact a mental health on call professional by calling 911. You are encouraged to leave a message for myself as well.

Confidentiality: Treatment services are best provided in an atmosphere of trust. It is important that you and I honestly discuss your issues and the progress being made in counseling. In order to guard this trust, everything that is discussed during your sessions is held in strict confidence. If you receive a call from our office, the business name will likely appear on your caller ID. If this is a problem, please let me know and we will find an alternative way of communicating when needed. There are, however, limits to my ability to maintain confidentiality. I and my billing staff are required to communicate to insurance companies involved in approving your services for reimbursement. These communications may occur by postal service or by facsimile machine. I am also required by law to report known/suspected incidents of child abuse, and circumstances where there is immediate danger to you or another person. Finally, and importantly, there are limitations to confidentiality in the event of a court order or subpoena.

Professional Records: Both the law and professional standards require that I keep appropriate treatment records. I handle these records carefully and keep them in locked filing cabinets, in a locked office, in a locked building to best protect confidentiality.

Termination: Termination is inevitable. Either you or myself may terminate our work together if either believes it is in your best interest. If a conflict arises with me, I ask that you communicate any concerns so this can be resolved in a therapeutic manner.

Charges: The customary charge for sessions are determined by contractual amounts reimbursed by insurance companies.

If your insurance changes, it is your responsibility to let me know as soon as possible so we can review new coverages and whether I am a provider for the new insurance coverage. This is important because some insurance companies require prior-authorizations. Failing to report changes in insurance can result in the patient self paying for services.

Billing: I have individuals who will be completing the medical billing for this practice. Both individuals have signed confidentiality statements and are bound by confidentiality standards. The medical billers do not have access to treatment information and/or records. Copays are due at the time of service. Cash, check and/or credit card payments can be made through Ivy Pay which is a HIPAA protected service.

Your signature notes you understand this service agreement and consent for treatment.

Client Signature: _____ Date:_____

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____