Individual Intake Information **How were you referred?** _____

Name of Patient _____ DOB_____

Address, City, & Zip_____ Email_____
(for scheduling & administrative purposes only)

Home Phone_____ Cell/Work Phone _____ Preferred method of contact_____

Occupation_____Employer & Address_____

Emergency Contact Person_____Relationship _____Phone_____

Circle One: Single - Engaged - Married - Divorced - Separated - Widowed // Currently in a relationship? Duration_____

Previous marriages? _____ Duration _____ Dates of marriage(s)_____

Highest Level of Education_____ Financial or Legal Problems?_____

Religious affiliation as a child _____ Religious affiliation as adult_____

Name of current partner/spouse_____ DOB_____

Occupation/Employer_____

Child(ren)'s Name(s), Date(s) of Birth, Grade, School (Living in and out of home if applicable)

_____

_____

Others Residing in Home _____How long at current residence?_____

Family History (Mark S for self, F for family member)

___Depression	___Anxiety	___Bipolar Disorder
___Alcohol/Substance Abuse	___Neurological Problems	___Physical Disabilities
___Learning Disabilities	___Attention Deficit Disorder	___Gastrointestinal Problems
___Emotional/ Physical/ Sexual Abuse	___Mental Illness	___ Physical Illness(ex:cancer)

Other_____

Raised by both parents? Y or N If no, with whom who did you reside?_____

Parents divorced? Y or N How old were you?_____ Adopted? Y or N If yes, how old were you?_____

If yes, contact w/biological mother?_____ biological father?_____

Significant family history/trauma: Relocation, Death, Abuse, Deployment, Conflictual Relationships

_____

_____

Mother's name, age, residence _____

Father's name, age, residence_____

Siblings names, ages, residences_____

_____

Other significant family members in your life?_____

Currently being treated by a physician & for what condition_____

Name of Physician_____

List current medications & dosage_____

List previous counseling/psychotherapy experiences: When, Who & Contact Info

_____

Symptoms/Behaviors of Concern (Please check all that apply) __Other_____

__Eating Less	__Acting Out Sexually	__Marital Relationship	__ Uncontrollable Anger/Temper
__Procrastinating	__ Sleeping Problems	__Socializing	__Overeating
__Attempting Suicide	__Disorganization	__Parent/Child Conflicts	__Obsessions/Compulsivity
__Poor Concentration	__Impulsivity	__Lack of Ambition/Goals	__Sexual Problems
__Crying	__Recklessness	__Peer Relationships	__Drug Use
__Social Withdrawl	__Irritability	__Nightmares	__Alcohol Use
__Skipping Classes	__Passivity	__ Body Image	__Addiction(Type)_____
__Binge Drinking	__Finances	__Spiritual/Religious	__Exercising too much or too little
__Injuring Self	__Career /Work	__Dating Concerns	__ Being Good to Yourself

Physical Symptoms you have recently been experiencing or have in the past (please check all that apply)

__Headaches	__Stomachaches	__Excessive tiredness	__Numbness/Tingling	__Hearing Voices
__Blackouts	__Tension	__Rapid Heartbeat	__Fainting	__Bowel Disturbance
__Vision Problems		__Excessive Sweating	__Pain	__Easily Startled

History of Medical/Mental Health Trauma_____

Previous Hospitalizations Where, When & Why_____

Cutting Behavior_____Thoughts of Suicide_____ Suicide Attempts_____When_____

Presenting Problem What specifically brought you in today? _____

_____

When did problems begin?_____What have you tried to resolve them? What works? What doesn't work?

_____

_____

Circle a number to rate the severity of the problem on a scale of 1-10 based on how much it impacts your daily functioning.

1	2	3	4	5	6	7	8	9	10
Little to no impact			Impacts my life to the extent that I am beginning to struggle and am self-conscious about it.			Extreme difficulty functioning in daily tasks including school/work/family/social life.			

What are your therapy goals?_____

_____

How would you know that it was getting better or improving?_____

_____

What are your strengths?_____

_____

Laurie L. Rosen, *LCSW • Licensed Clinical Social Worker*
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Payment Contract

-This Payment Contract between Laurie L. Rosen, LCSW & _____(name of "Responsible Party") establishes that the above "Responsible Party" agrees to make all payments in full by **cash or check**, payable to Laurie L. Rosen, LCSW, due at the time session**.**
-If patient misses or cancels a session with less than 24 hours advance notice, "Responsible Party" agrees to pay half the session fee ($75) for that missed session, which is not to be submitted to health insurance for reimbursement.
-"Responsible party" understands this mental health provider is out-of-network with all health insurance carriers.
-"Responsible Party" agrees to submit their own claims if seeking reimbursement.
-"Responsible party" agrees to pay any amounts charged in an attempt to collect fees via attorney or collection agency, which may be used for a balance delinquent past 30 days, unless arrangements for a payment plan have been made.
- "Responsible Party" understands treatment may be terminated until such time that all delinquent fees have been paid.

Fee for psychotherapy session (TBD w/ therapist)_____

_____ _____
Signature ***Date***

Notice of Privacy Practices & Informed Consent (PLEASE INITIAL BELOW)

_____I have received a copy of or have been instructed as to where I can access the Notice of Privacy Practices (NPP), informing me about how my Protected Health Information (PHI) may be used and disclosed, and how I can get access to this information. It is my responsibility to request a copy if I so desire.

_____I understand that much of the work of therapy will be to resolve issues, and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is painful and difficult. I understand that "homework" such as reading, written exercises, and changing behaviors may be prescribed as part of my treatment. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

_____I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent EXCEPT in cases of: abuse, being at risk for harming myself or others, couples therapy, utilizing collection agencies for unpaid balances, and obtaining payment from health insurance companies. Without using my name, I understand my therapist may share information about my case when consulting with colleagues for purposes of treatment planning. I agree to the above statements and hereby agree to enter into a therapeutic relationship with Laurie L. Rosen, LCSW.

_____I understand that 30 days from my last session without any follow-up appointment or communication, my case will be considered closed and the therapeutic relationship terminated. However, I may call for an appointment to resume therapy anytime contingent upon scheduling availability.

ADDITIONAL FEES: I understand there are additional fees to be paid should I request documentation about my treatment (ex: correspondence, reports, or forms). I agree NOT to petition this therapist to appear in court as a witness for custody hearings, trials, or other domestic issues. I understand any attempt to petition this therapist to court would nullify the confidentiality of my records and may be more damaging to my case. In the event a petition is served to this therapist, it will include payments of $300/hr with a minimum of 4 hours ($1200) for my services. This includes but is not limited to: wait time, time for meals, transportation, time to testify, depositions). I understand compensation for court appearances are paid in full to my therapist prior to the court date.

_____ _____
Signature ***Date***

As your therapist, I will bring the best that I know from my study and experience, insight and wisdom. I will keep a holistic perspective in our work together because I believe that the mind, body, and spirit all work together to form the wholly healthy person. You can expect truth from me even when you may not want to hear it. I will provide a safe place where you will experience compassion and empathy on your journey. Thank you for the privilege to share in your life, learning, and growth.
Laurie