Client Contact Information

Please alert your clinician in the event that your contact information changes.

_____

First Middle Last

Today's Date: ____/____/_____ Nickname_____

Date of Birth: ____/____/_____ SSN: _____-____-_____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Email:_____

Employer: _____Occupation: _____

Gender: Male Female Transgender Genderqueer/Nonconforming Other_____

Marital Status: Single Married Separated Widowed Divorced Partnership

If there is an emergency or your therapist becomes concerned that you may harm yourself or others, the therapist is required to contact someone close to you. **Emergency contact information:**

Name:_____Phone:_____

Relationship to you: _____

Appointment reminders, billing information and other health forms are considered Private Health Information. By selecting to receive this information, you waive your right to keep this information completely private.

I agree to receive appointment reminders via text or email as previously selected.

- Yes
- No

Authorized IWC staff may email, fax, or mail completed forms, including forms that may contain confidential information.

- Yes
- No

Authorized IWC staff may email, fax, or mail billing information and/or receipts for my care.

- Yes
- No

Adult Intake Packet

Safety:

On a scale of 1 to 10, (ten being strongest) how strong is your desire to live currently? _____

Have you ever used self injury as a coping skill? (ex. Cutting, biting, pulling out hair, etc.)

_____

Have you ever tried to kill or harm yourself before?_____ How?_____

Current Symptoms Checklist:

- ☐ Depressed mood
- ☐ Racing thoughts
- ☐ Excessive worry
- ☐ Unable to enjoy activities
- ☐ Impulsivity
- ☐ Anxiety attacks
- ☐ Sleep pattern disturbance
- ☐ Increase risky behavior
- ☐ Avoidance
- ☐ Loss of interest
- ☐ Increased or decrease in libido
- ☐

- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ Concentration/forgetfulness
- ☐ Decrease need for sleep
- ☐ Change in appetite
- ☐ Fatigue
- ☐ Excessive energy
- ☐ Crying spells
- ☐ Excessive guilt
- ☐ Increased irritability
- ☐ _____

State the reason you are here in your own words:_____

_____

How long have you been dealing with the present issue?_____

Prior Therapy? ( ) Yes ( ) No

If yes, Please describe when, by whom, and nature of therapy:

_____

_____

Please sign if you give us permission to consult Current/Past Therapist/Counselor?

X_____

Mental Health Hospitalization? ( ) Yes ( ) No

If yes, describe for what reason, when and where.

_____

_____

Trauma/Abuse History:

Have you ever experienced or witnessed any abuse? ( ) Yes ( ) No

If yes, was it: VERBAL EMOTIONAL PHYSICAL SEXUAL (Circle all that apply)

Have you ever experienced or witnessed a traumatic event? If yes, please explain:

_____

_____

Nightmares or flashbacks which cause immobilizing anxiety? ( )Yes ( )No

Family Mental Health History:

Has anyone in your family been diagnosed with or treated for a Mental illness? ( )Yes( )No

If yes, please explain: _____

_____

Medical History:

Primary Care Physician_____

Date of last Check Up: (month/year) _____

List current medical concerns: (if none, write none)

_____

Medications: List any medications you have taken in the past or are currently taking.

Past: Current:

_____ _____

_____ _____

_____ _____

Who prescribes the current medications to you? _____

Permission to contact the above Primary Care Physician and/or prescribing physician?

X_____

Substance Use:

How many days per week do you drink alcohol? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any illegal substances in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long?

_____

Integrated Wellness Clinic

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____Tea _____

How you ever smoked cigarettes? ( ) Yes ( ) No

Have you ever been treated for substance dependency? ( ) Yes ( ) No

If yes, for which substances, where were you struggling with?

_____

Family/Household History:

Check all of the following which your family/household has experienced past and/or present:

- ☐ Financial problems
- ☐ Frequent moves
- ☐ Job changes
- ☐ Drinking/drugs
- ☐ Arguments
- ☐ Separation or divorce
- ☐ Remarriage of parents
- ☐ Separation from siblings
- ☐ Frequent physical punishment
- ☐ Physical confrontations between parents
- ☐ Mental illness in family
- ☐ Physical illness in family
- ☐ Hospitalization of parent
- ☐ Death in family
- ☐ Incestuous behavior in family
- ☐ Other (please explain)

_____

_____

Relationships: Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation?

_____

Describe your relationship with your spouse or significant other:

_____

On a scale of 1-10 (10 being close to “perfect”) How would you rate your current relationship?_____

Have you had any prior marriages? ( ) Yes ( ) No.

If so, how many? _____ How long?_____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:

_____

List everyone who currently lives with you:

_____

How many hours a week do you spend engaging in social/peer relationships (friends):_____

Do you make friends easily?_____ Keep friends easily?_____

If No to either, please explain:_____

Educational/Developmental History:

Any developmental struggles between birth and adolescence (e.g. walking, crawling, feeding, learning, puberty, etc)?_____

Highest Grade Completed? _____ Where?_____

Did you attend college? _____ Where? _____

Major? _____ Highest educational level or degree attained? _____

Occupational History:

Currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired How long?_____

What is/was your occupation?_____

On a scale of 1-10 (10 being nearly "perfect") please rate your performance with your daily responsibilities:_____ Rate your satisfaction with these daily responsibilities:_____

Have you ever served in the military? If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge: _____

Legal History:

Have you ever been arrested? _____ Do you have any pending legal problems? _____

If yes to either, please describe circumstances:_____

Perception of self:

On a scale of 1-10 (10 being nearly "perfect"), please rate your perception of self:_____

List your coping skills:

_____

What do you hope to accomplish through counseling? _____

_____

Is there anything else that you would like me to know? _____

_____

Signature: X _____**Date:**_____

Billing Declaration Statement

CONFIDENTIALITY

Integrated Wellness Clinic is a provider of mental health services. Your right to privacy is important to us and information you discuss during your treatment is confidential. (In certain circumstances, we may be required by law to disclose health information.) Your information will also be released to process insurance claims. If you have questions about this prior to your visit, please call the clinic manager at (225) 924-1910 or talk with your mental health provider at the time of your visit.

CLINIC FEES

You will receive a bill from Woodlake Management, LLC, parent organization of Integrated Wellness Clinic, for professional fees. Fees charged will depend on the services you are provided. For specific fee information, please consult the Woodlake Management accounting department. Your insurance policy is a contract between you and your insurance carrier. We will prepare and submit your claim forms if insurance information is provided to us. Review your policy with your insurance carrier prior to your first appointment to determine what benefits and coverage your specific policy allows. Some insurance carriers require a physician's referral or a pre-certification for mental health services. If your insurance carrier requires that Integrated Wellness Clinic obtain authorization before providing psychiatric services, your insurance company should provide you with a copy of this authorization. This does not guarantee payment. It is your responsibility to monitor your benefits and read the statements you receive from your insurance company. Once your insurance benefits are exhausted, your account will be coded for self-pay and billed accordingly. Financial responsibility is ultimately yours.

CANCELLATION OF APPOINTMENTS

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily. Patients will be charged a fee of $40 per session for the first missed appointment or late cancellation (less than 24 hours' notice) unless there is an emergency or unavoidable circumstance. The second missed appointment will result in a fee of $50. Insurance carriers do not pay no-show/late cancellation fees and patients will be billed directly. If you miss three or more appointments without appropriate notice, you may receive a warning letter stating that further missed appointments will result in termination of care at this clinic and you will need to seek services elsewhere.

Signature: X _____**Date:**_____

Recurring Payment and Missed Appointment Authorization

Patient Name:_____

Please complete the following information:

I, _____, authorize Integrated Wellness Clinic (Woodlake Addiction Recovery Center) to charge the credit card indicated below in the amount of $_____ after each appointment. In the event I fail to attend, or cancel my appointment within 24 hours, I authorize IWC to charge my card $40.00 for cancellation/no show fee.

Billing Address: _____

_____

Phone#: _____

Credit Card Information

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name: _____

Card Number: _____

Expiration Date: _____ CVV#_____

Session/Copay Amount: _____Missed Appt Fee: $40.00

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Woodlake Addiction Recovery Center in writing of any changes in my account information or termination of this authorization. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Woodlake Addiction Recovery Center may at its discretion attempt to process the charge again within 30 days. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

PATIENT STATEMENT

I have read and understand the above information.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

Release of Information

By signing below, I hereby authorize Integrated Wellness Clinic and/or Woodlake Management, LLC to release and/or to obtain information with respect to any medical. psychiatric, drug and/or alcohol related conditions obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers listed below. The type of information authorized for disclosure includes, but may not be limited to, that which is indicated below. I understand that my signature below will not have any effect on the ability or inability to determine, limit or restrict my treatment.

Patient Name: _____

Release to:
Name: _____

Relationship to Client:_____

Address:_____

Phone Number:_____

Purpose of Disclosure:
☐To identify persons supporting and using services
☐To aid in diagnosis/continuing care/and treatment
☐To facilitate understanding and support in treatment
☐To aid in continuing care and treatment
☐Other:_____

Type of Information to be Disclosed:
☐Notification of admission and discharge/including assessment/UDS/attendance/discharge plan/summary
☐Progress and treatment reports/including attendance
☐History and Physical and Psychosocial Assessment
☐Notification of admission/information on patient treatment plan/discharge/continuing care/financial
☐Progress and treatment reports/including group/individual/family sessions/attendance/other
☐ History and Physical/consultation reports
☐Progress and treatment reports.
☐Other:_____

The above release, initialed by me may be revoked or revised by me in writing at any time. If not previously revoked, the release will expire 1 year of date of signature below. I understand I have a right to receive a copy of this authorization.

This release is valid until: _____

Confidentiality Prohibition on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations(42 CFR Part 2 and 45 CFR HIPAA) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature:_____Date:_____

Witness Signature:_____ Date:_____