LaForty Counseling Services

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____
_____
_____
_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____
_____

3. What do you consider to be some of your strengths? _____
_____
_____
_____

4. What do you consider to be some of your weaknesses? _____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy? _____
_____
_____

Thank you for selecting LaForty Counseling Services. We strive to provide the highest quality and most professional services for promoting your well-being. If you ever have any questions or comments, please contact our office at **(205) 664-8787**. Our phones are generally answered Monday-Friday 8am-5pm. If necessary, please leave a message and we will return your call as soon as possible. If you are experiencing an emergency, please call 911 or the Crisis Center line at (205) 323-7777, or go to the nearest hospital Emergency Room.

Confidentiality: All counseling appointments, records, and identification information are kept strictly confidential and are shredded after 7 years. The limits of confidentiality apply when the clinician considers a client to be in danger of harming others or him/herself, if the records are subpoenaed, or when the client grants disclosure of information through a signed release form. Alabama law requires that child abuse be reported to the Department of Human Services. Support staff will have limited access to information regarding clients only as is needed as they make appointments and perform ordinary business operations.

Length of Session: The length of counseling sessions will be forty-five (45) to fifty-five (55) minutes. Your clinician will also spend time reviewing your progress notes, evaluating assessments, making new notes, etc. If you arrive late for your session, the missed time is forfeited in order to meet the needs of our clients. Always check in with the front office when you arrive for your appointment by signing in and paying for services. If you have been waiting more than 15 minutes after your scheduled time, please let our staff know.

Phone Calls: Due to the nature of our clinicians' schedules, telephone contact outside of regular sessions is rarely possible. Exceptions are made at the sole discretion of your clinician, and as his/her schedule allows. Telephone sessions lasting longer than 10 minutes will be billed to you at a rate of $40 for up to a 30-minute call. Calls lasting longer than 30 minutes will be billed at the regular session rate. If you are experiencing an emergency, call 911 or the Crisis Center line at 323-7777, or go to the nearest hospital Emergency Room.

Cancellations & Missed Appointments: Keeping track of scheduled appointments is the responsibility of the client and/or guardian. Reminder calls are made as a courtesy only. If you do not receive a reminder call, you are still responsible for keeping your appointment. If you must cancel your appointment, please call by 12:00pm noon the business day before your appointment to avoid a $25 charge. Monday appointments must be cancelled by noon on Friday. This office does not double book appointments, and missed appointments or late cancellations will be billed to you at the rate of $25 per session. Because of the nature of our schedule, clients who miss two appointments or repeatedly cancel appointments will be referred to another clinician's office.

Side Effects: Counseling is not always easy, and you may find yourself discussing very personal information. It is possible that you might become anxious during and after these conversations. As you learn more about yourself and your relationships, you may have increased conflicts with others and may become somewhat depressed. Counseling is meant to help alleviate your problems, but as you first delve into your problems, your symptoms may become more acute. You may be asked to try new ways of doing things, and we cannot guarantee particular results or outcomes.

Court Appearances: All court/deposition appearances must be scheduled in advance due to the clinicians' full schedule. A subpoena is REQUIRED for all court/deposition appearances. Once the clinician is subpoenaed for a court/deposition appearance, a retainer of $1200.00 will be required at the time of the subpoena. At that time, the clinician's schedule will be cleared to accommodate the court/deposition appearance. The clinician charges a non-refundable preparation fee of $1000.00 for any court/deposition appearance and said fee is considered earned upon receipt. The remainder of the fee is credited to actual time for appearance at the rate of $100.00 per hour to include travel time. If the actual time is expected to exceed the prepayment of two hours, additional prepayment of fees must be made prior to the date of the subpoenaed testimony. Any cancellations will entitle the individual a refund only of the funds paid over the $1,000.00. Any continuance will require additional payment of fees for the additional time devoted by the clinician and the clearing of their schedule for the same. By signing on the acknowledgement page, you are agreeing to fully comply with this policy regarding court/deposition appearances.

Documentation: If you require documentation, such as FMLA paperwork, school forms, notes for your employer, etc., these must be requested prior to the start of your appointment, and will be completed by your clinician during that appointment. If you require documentation outside of an appointment, you will be charged an average of $50, depending on the complexity of the paperwork. These fees must be paid prior to the clinician completing the requested document.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of LAFORTY COUNSELING SERVICES. I authorize LAFORTY COUNSELING SERVICES to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that LAFORTY COUNSELING SERVICES may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

Termination of Treatment: Treatment in this practice will be terminated immediately for non-compliance with treatment plan, abuse of staff or other clients, bringing a weapon into our facility, repeatedly missing or cancelling appointments, non-compliance with medication policy, non-payment of account, and/or any action or attitude that causes an inability to achieve or maintain rapport between the client and clinician.

Payments: Payment of services is expected at the time of your visit and prior to the beginning of the session. Additional terms: I hereby authorize the use of my credit/debit card to pay for appointments. I hereby further authorize LaForty Counseling Services, to maintain a copy of my card on file and to charge my credit card for any amounts due and payable and give my permission to charge the same on the credit/debit card on file in case for any late cancelations or no-show fees. _____

By signing your name below, you are acknowledging that you have read the informed consent and agree to the terms of services. (Client will provide a copy of their license/identification card for the file)

_____
Printed Name of Client or Guardian

_____ _____
Signature of Client or Guardian Date