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.

Patient Information	**No Show/Late Cancellation Policy**
Release of Information	**Minor Policy**
Consent for Treatment	**Intake Questionnaire**
Notice of Privacy Practice	****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 7:30-5pm & Friday between 7:30am-4pm @ 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.

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The Counseling Center

PATIENT INFORMATION

Last Name: First Name: Middle Initial: Nickname/AKA:

Date of Birth: Social Security Number: Pronoun: How would you like us to address you?
☐ She/ Her ☐ He/ Him Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other Language other than English

Address: Apt #: City: State: Zip Code:

Home Phone: Cell Phone/Other:

Email Address:

Employer: Employer Phone:

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: Referring Physician:

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient : ☐ Self (If self, skip to Insurance Information) ☐ Spouse ☐ Parent ☐ Other:

Last Name : First Name: Middle Initial:

Date of Birth: Social Security Number:

Address: Apt #: City: State: Zip Code:

Home Phone: Cell Phone/Other:

Employer: Employer Phone:

INSURANCE INFORMATION

Primary Insurance Co: Policy Number: Group Number:

Policy Holder Last Name: First Name: Date of Birth: Phone:

Address: Apt#: City: State: Zip Code:

Are you using an Employee Assistance Program? (EAP): EAP Company: Auth #: # of Sessions Approved:

Secondary Insurance Co: Policy Number: Group Number:

Policy Holder Last Name: First Name Date of Birth: Phone:

Address Apt# State Zip Code

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EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name: **First Name:** **Phone:**

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 **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 **$160** 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.

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

Thank you again for choosing The Counseling Center for your Mental Health needs.

We understand that emergencies happen, or you get sick without any notice or warning. Please call the office to learn about your options if you have any questions.

Our office No Show/ Cancellation policy is:

1st No show/ Late Cancellation is forgiven
2nd No Show/ Late Cancellation- May result in a $25 fee and or schedule restrictions.
3rd No Show/ Late Cancellation- $75 fee and or Counseling Relationship Terminated.
1st Intake Appointment No Show without any contact: there maybe a 3-4-month delay getting you rescheduled again.

Our office will place a courtesy phone call reminder 2 days prior to your 1st appointment and sends text messages 1 day prior to your scheduled appointment day.

How to cancel your appointment:

To cancel or reschedule your appointment please call The Counseling Center at **541-928-2710**. If you have any problems getting through, you can leave a confidential message with your name, appointment date and time, and cancellation reason or request for a rescheduled appointment. Please leave your phone number and a good time to reach you.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient Printed Name Date

_____ _____
Office Staff Signature Date

Copy given to client _____
(Client's Initials)

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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 allow an hour to 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 come to your appointment 15 minutes early with your completed questionnaire so that we may scan and input your information.

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

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Adult Intake Questionnaire

Name (first, middle, last): _____

Date of Birth: _____

Age: _____

Gender: _____

Preferred Language: _____

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

Race/Ethnicity: _____

Date of Evaluation: _____

Referral Source: _____

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

Were you raised in a particular religion or spiritual practice? If so, what? _____

Do you have a current spiritual practice? _____

Reasons you are seeking help.

Areas of Concern:

☐ Relationship issues	☐ Recent loss or death	☐ Chronic pain/illness
☐ Parenting/Family issues	☐ Grief issues	☐ Sexual problems
☐ Job problems	☐ Drug use	☐ Abuse issues (emotional, sexual, physical)
☐ School issues	☐ Alcohol use	☐ Other traumatic event(s)
☐ Financial problems	☐ Recovery issues	

Other Issues (PLEASE CIRCLE ALL THAT APPLY):

Self-control: anger, sexual impulses, food, excessive spending, emotions, mood swings, feeling overwhelmed

Food issues: anorexia, bulimia, compulsive eating, binge eating, lack of appetite, recent weight loss or gain

Thinking: disorganized or unwanted thoughts, memory loss, difficulty making decisions

Other: _____

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Current Symptoms:

- ☐ Racing heart
- ☐ Chest pain
- ☐ Trembling
- ☐ Diarrhea/vomiting
- ☐ Fear of leaving home
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Obsessive fears
- ☐ Excessive worrying
- ☐ Panic attacks
- ☐ History of anxiety/panic
- ☐ Fear of _____
- ☐ Low self-esteem
- ☐ Difficulty concentrating
- ☐ Memory problems
- ☐ Low energy/fatigue
- ☐ Helplessness/hopelessness
- ☐ Excessive guilt
- ☐ Disinterest in activities
- ☐ Lack of motivation
- ☐ Sleep difficulties
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Depression/unhappiness
- ☐ History of depression
- ☐ Abnormal body sensations
- ☐ Auditory hallucinations
- ☐ Visual hallucinations
- ☐ Feeling others plotting against client
- ☐ Doing things not remembered later
- ☐ Feeling of not needing sleep
- ☐ History of bipolar disorder
- ☐ Grandiose Plans/Thoughts
- ☐ Nightmares/night terrors
- ☐ Flashbacks
- ☐ Seizures
- ☐ Hyperactivity

Other Symptoms:

_____

_____

History of Presenting Problem(s):

_____

_____

_____

_____

_____

_____

_____

_____

Previous Mental Health Treatment

Have you previously been seen at the Albany Counseling Center? Yes ☐ No ☐

Previous Counseling	When	Reason/Diagnosis/Other pertinent information

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Current Medication

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

List all vitamins and herbal supplements:

1. _____
2. _____
3. _____

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

Have you had any adverse reactions to past psychotropic medication? Yes ☐ No ☐

If yes, please explain_____

Current Living Situation

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

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Family/Interpersonal Relationship History:

Developmental History

Did mother or father use drugs before your birth? During pregnancy?	☐ No ☐ Yes - *If yes, 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:*
Additional information:	

Did your family have difficulty in the following areas?:

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

Describe childhood and significant events:

_____

_____

_____

_____

Abuse/Trauma History:

_____

_____

_____

_____

Ever witness either parent being abused? Explain:	☐ No ☐ Yes

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Social History -- Relationships

	Name	Age	Describe the Quality of These Relationships
Biological Mother			
Mother/ Caregiver			
Biological Father			
Father/ Caregiver			
Grandparents/ Others Involved			
Siblings			
Spouse, Partner, Significant Other			
Children, Full Half Step			

Positive support systems	☐ None ☐ Poor ☐ Adequate ☐ Exceptional
Friends	
Co-Workers	
Other	

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Highest Level of Education				Licenses or Special Training
Grade School	☐	Home schooled	☐	
Middle School	☐	Special ed/learning disabled	☐	
High School	☐	504 Plan	☐	
2-Year College	☐	IEP	☐	
4-Year College	☐			
Master's Degree	☐			
PhD	☐			
MD	☐			

Military service Yes ☐ No ☐ Branch _____ Deployments _____

Currently Employed ☐ Full time ☐ Part time ☐ Stay-At-Home Parent

Where Employed _____

Shift work? ☐ Hours _____

If unemployed, last job held _____

Volunteer Positions? ☐ Where? _____

Your Medical History

Conditions		Additional Information (onset, treatment, etc.)
Diabetes?	☐ No ☐ Yes	
Heart Disease (high blood pressure, heart attacks)?	☐ No ☐ Yes *- If yes, what:*	
History of stroke?	☐ No ☐ Yes	
Lung disease (Asthma, COPD, Emphysema)?	☐ 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 or loss of consciousness?	☐ No ☐ Yes	
Chronic pain?	☐ No ☐ Yes- *If yes, explain:*	
Any other health conditions/disabilities?		
Allergies	☐ No ☐ Yes - *If yes, explain:*	
Surgeries?	☐ No ☐ Yes - *If yes, explain:*	
Number of pregnancies and number of births?		
Immunizations	Follow recommended guidelines for vaccinations ☐ No ☐ Yes	

Primary Care Physician: _____ **Date of last exam:** _____

Sleep/ Eating/ Self-Care:

Hours of sleep 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 ☐ No Type of exercise? _____

Eat healthy (vegetables/fruits) daily? Yes ☐ No ☐

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Drug and Alcohol History

Substance abuse?	☐ No ☐ Yes			
Impact of substance abuse	☐ Relationship ☐ Job ☐ School ☐ Family ☐ Other_____			
History of treatment?		☐ No ☐ Yes - *If yes, explain:*		
In treatment?		☐ No ☐ Yes		
What kind?		☐ Outpatient ☐ Intensive Outpatient ☐ Residential Facility ☐ Hospitalization		
Treatment – where & when				
Type	**Heaviest Used**	**First Use**	**Last Use**	**History/pattern of use (daily, 1xweek, etc.)**
Alcohol				
Cannabis				
Cocaine				
Hallucinogens				
Inhalants				
Nicotine				
Opioids				
PCP				
Sedatives, Hypnotics, Anxiolytics				
Methamphetamine				
Drug of choice?		☐ No ☐ Yes - *If yes, what:*		
Times quit for more than one month?				
Tobacco use?		☐ No ☐ Yes - *If yes, how much:*		
Additional information:				

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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 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 ☐ 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) ☐ Core values/beliefs (including religious) ☐ Sense of purpose ☐ Ability to cope with stress/frustration tolerance
History of harming others?	☐ No ☐ Yes - *If yes, explain (i.e. dates, triggering events, method, remorse, etc.):*
Currently homicidal	☐ No ☐ Yes - *If yes, explain:*
Most recent homicidal ideation? Intent or 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

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