IN-DEPTH COUNSELING INTAKE QUESTIONS

NEW BEGINNING COUNSELING CENTER – SAMUEL R. SCHUTZ, PH.D.

2500 Main Street, Suite 211
Tewksbury, MA 01876
Telephone, 978-406-1321

Instructions

Please download and print **ALL** the following pages 1-8. Please fill them out completely and bring one copy with you to your first counseling session, for me to keep and place in your personal and confidential file.

The labor you invest in completing this work will make it possible for me to serve you well as your counselor. Your investment of time *now* will save you literally hours of counseling that would otherwise be spent by my asking you this information during our sessions together.

In order to protect your privacy, I am prohibited by law from receiving this information from you by email attachment, by fax, or by scanning. This necessitates your printing the forms and bringing the information with you. Thank you for your understanding and cooperation.

I look forward to seeing you at our scheduled appointment.

You will find on the following pages:

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SECTION I: REGISTRATION FORM

(Please Do Not Leave Any Blanks, and PRINT Neatly)

Today's Date: _____

PATIENT INFORMATION

If Patient is a Child or Adolescent, this Page is to be Filled Out as PARENT INFORMATION

YOUR NAME: Last_____ First_____ Middle_____

Street Address_____ City_____ State_____ Zip_____

PHONE Mobile ( )_____ Home ( ) _____ Work ( ) _____

EMAIL ADDRESS_____

BIRTH DATE_____ AGE_____ SEX: _____Male _____Female

EMPLOYER (if applicable) _____ Your Position_____

MY PAYMENTS

(Required)

I agree to pay my responsible portion at each counseling session in **cash** or **check** as I choose. Check is made out to **A New Beginning Counseling**. If my check is returned because I have insufficient funds in my account I agree to pay an additional $30 fee relating to the returned check.

Your Name (Print):_____ Signature_____ Date_____

INSURANCE INFORMATION

(if applicable)

Person Ultimately Responsible for Bill: _____

Primary Insurance Company:_____ Patient's Name on Insurance Card_____

Subscriber's Name: __ _____ Policy Number: _____

Subscriber's Date of Birth (Mo/Day/Yr): _____/ _____ / _____

Patient's Relationship to Subscriber: ____Self ____Spouse ____Child ____Other (specify)_____

Annual Deductible: $_____ Currently Paid in Full? ___Yes ___No

Co-pay for Each Visit: $_____ Effective Date of Insurance: _____

INSURANCE PAYMENT AUTHORIZATION (if applicable)

I authorize SAMUEL R. SCHUTZ to release to my insurance company any information necessary to process this claim.

Your Name (Print):_____ Signature_____ Date_____

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SECTION II: PRIVACY STATEMENT

Our Commitment to Your Privacy

A New Beginning Counseling Center is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. We will use the information about your health which we get from you or from others mainly to provide you with personal **treatment,** to arrange **payment** for our services or for some other business activities which are called**,** in the law**,** health care **operations**. After you have read this Privacy Statement we ask you to sign the following **Consent Form** to let us use and share your information in these ways. If you do not sign the Consent Form (next page)**,** by law we cannot treat you.

If we or you want to use or disclose/release your information for any other purpose than stated in the last paragraph we will discuss this with you and ask you to sign a **Legal Authorization Form** to allow this. An example would be if you wished to allow a personal consultation between myself and your personal physician regarding medication.

Of course we will keep your personal health information (**PHI**) private but there are some rare times when the laws require us to report without the client's consent, such as:

- suspected child abuse, or abuse of the elderly, or abuse of a special needs person
- If we come to believe there is a serious threat to your health or safety or that of another person or the public, we must disclose some of your PHI to those persons who can prevent the danger.
- some lawsuits and legal or court proceedings.
- If a law enforcement official requires us to do so.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will do our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your personal care or the payment for your care. While we don't have to agree to your request, if we do agree we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. With the exception of the Progress Notes (actual therapy notes), you can inspect, read, any and all aspects of your healthcare records, such as your medical and billing records. You may even get a copy of these for a minimal charge to cover administrative expenses.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your information. You have to make this request in writing. You must tell us the reasons you want to make the changes.
5. You have a right to a copy of this notice.

If you have any questions regarding this notice or our privacy policies, please contact Dr. Samuel R. Schutz, who can be reached by phone at 978-406-1321 or by email at samschutz@gmail.com

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SECTION III: CONSENT FORM
TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between me, Samuel R. Schutz, and you as client or you as your child's parent or legal guardian. When we use the word "you" below it will mean your child if you print his or her name below.

Name of Client (print): _____
Or Parent or Legal Guardian, if applicable

Name of Child (print), if applicable: _____

When we examine, diagnose, treat, or refer you we will be collecting what the law calls protected health information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others as described in the Privacy Statement previous page). The Privacy Statement explains in more detail your rights and how we can use and share your information. Please read the Privacy Statement before you sign this Consent Form.

If you do not sign this consent form by agreeing to what is in our Privacy Statement, by law we cannot treat you.

You have the right to ask us not to use or share some of your information for treatment with other agencies such as your insurance company, others assisting you in your payment, or for administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter and telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that. We may also no longer be able to treat you.

_____ _____
Signature of Client (or Child's Parent or Legal Guardian) Date

_____
Signature of Adolescent (if applicable)

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SECTION IV: CONTRACT & SIGNATURE OF AGREEMENT

1. A normal counseling session is 45 minutes.

2. You will be charged in accordance with your insurance policy.

3. Without insurance the out-of-pocket fee for the first counseling session is $190 (that includes a complete diagnostic analysis and initial treatment plan), and thereafter $130 for individual psychotherapy and $150 for couple or family counseling. For those who qualify there is an alternative fee structure which is on a sliding scale based upon family income ability to pay.

4. You must cancel at least 24 hours prior to your scheduled visit by calling or texting the above telephone number. Otherwise, **you will be charged your normal FULL FEE as indicated above.** You hereby agree that if you fail to cancel within the 24 hour time period your session will be charged your normal full fee**, unless I waive that fee due to a verifiable emergency or illness that prevented you from honoring this cancellation requirement.**

5. You will make payment at the beginning of each counseling session either by cash or check made out to A New Beginning Counseling.

6. If you have applicable insurance I will as a courtesy to you submit your charges to your company on your behalf through my bookkeeper. However, be aware that **you and not your insurance company are ultimately responsible for your bill**. Therefore, learn from your insurance company (1) your **deductibl**e if any (what you must pay before insurance will pay anything), (2) your **copay** if any (your own payment responsibility for each visit), and (3) your total number of visits allowed per year. Continued counseling may require "prior authorization" which I will handle on your behalf with your insurance company.

7. Telephone consultations are charged at the same rate as in-person sessions, and generally are not covered by health insurance.

8. For reasons of security I do not receive or send any emails or texting relating to your personal counseling issues.

9. We may use texting and/or telephone to schedule or cancel appointments.

10. If you wish to leave me a message, the above telephone number records your calls and your texting, and only I have access to these messages. I attempt to monitor recorded messages at least once every 24 hours. However, because of the nature of my counseling practice as an outpatient clinic, I cannot be available for emergencies 24 hours a day, 7 days a week**. In case of emergency, call the emergency room of your local hospital**.

11. Although I always strive toward the healing of marriage, it is possible that in the course of therapy you may become involved in a divorce or custody dispute. If this occurs, I want you to understand that I will not be available to provide expert testimony in court, and your signature here indicates your agreement. This decision is based on two factors**:** (1) because my evaluation will be seen as biased in favor of you because we have a therapeutic alliance, and (2) because I may not agree with you about what is best, and so my taking a role other than your therapist could be detrimental to your therapy. With regard to children, I recommend you engage a court-appointed or court-approved child custody evaluator.

12. You may begin or end therapy at any time. While you have no legal obligation to do so, it is customary to discuss your desire to terminate at least a week in advance.

If you have any questions about anything discussed herein, or about our therapy in general, please feel free to bring them up to me at any time.

I **HAVE READ AND AGREE TO ALL THE ABOVE INFORMATION:**

Signature_____ Date_____

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SECTION V: CLIENT INFORMATION FORM

If Client is an Adolescent, this Form is to be Filled Out by the Adolescent.

CLIENT NAME (Print):_____ **DATE**:_____

CLIENT ADDRESS_____
(Street, City/Town, **Zip**)

PHONE: Cell ( )_____ Home ( )_____ Work ( )_____

SEX: ___M ___F **AGE**:_____ **DOB**:_____/_____/_____ **Soc. Sec. #** _____

OCCUPATION/EMPLOYER_____

Who referred you here for counseling? _____

Why have you come for counseling? _____

_____

_____

What happened, *specifically*, that caused you to come *at this time*? _____

_____

_____

YOUR FAMILY OF ORIGIN: (*Names* & Approx. *Ages* of FATHER, MOTHER, STEP-PARENT, SIBLINGS): ***print***

NAME:	RELATIONSHIP:	AGE:	NAME:	RELATIONSHIP:	AGE:
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Are your parents divorced? ___Yes ___No

CHURCH OR SYNAGOGUE (if applicable):_____

MARITAL STATUS: ___MAR ___SGL ___LIV TOG. ___DIV ___SEP ___WID P**REVIOUS MARRIAGES?** ___ Yes ___No

ANNIVERSARY DATE (if married): _____

EDUCATION (highest grade completed / degree earned / school): _____

YOUR IMMEDIATE FAMILY: (PRINT)

NAME:	**AGE:**	**NAME:**	**AGE:**
(Spouse) _____	_____	(Children)_____	_____
(Children)_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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SECTION VI: CHECKLIST OF CONCERNS

If Client is an Adolescent, this Form is to be Filled Out by the Adolescent.

CLIENT NAME (Print):_____ **DATE**:_____

Instructions: This section is VERY IMPORTANT. Please mark ALL of the items below that apply to your life [if past, write "past" next to that item]. Feel free to make brief comments after any item.

- **Abuse OF You by Others – specify ___physical, ___sexual, ___emotional, ___neglect**
- **Abuse BY You of Others – specify ___physical, ___sexual, ___emotional, ___neglect**
- **Alcohol use – specify ___by you, ___by others.**
- **Anger, hostility, arguing, irritability – specify ___by you, ___by others**
- **Anxiety, nervousness**
- **Attention, concentration, distractibility**
- **Body pain – headaches, or other kinds of pain**
- **Career concerns, goals, choices**
- **Childhood issues (your own childhood)**
- **Children, child management, child care, parenting**
- **Codependence**
- **Confusion**
- **Compulsions**
- **Custody of children**
- **Decision making, indecision, mixed feelings, putting off decisions**
- **Delusions (false ideas)**
- **Dependence**
- **Depression, low mood, sadness, crying**
- **Divorce, separation**
- **Drug abuse – prescription or over the counter medications, street drugs**
- **Eating problems – overeating, undereating, poor appetite, vomiting (see also below, "weight and diet issues")**
- **Emptiness**
- **Failure**
- **Fatigue, tiredness, low energy**
- **Fears, phobias**
- **Financial or money troubles, debt, impulsive spending, low income**
- **Friendships**
- **Gambling**
- **Grieving, mourning, deaths, losses, divorce**
- **Guilt**
- **Health, illness, medical concerns, physical problems**
- **Inferiority feelings**
- **Interpersonal conflicts**
- **Impulsiveness, loss of control, outbursts**
- **Irresponsibility**
- **Judgment problems, risk taking**

(continued on next page)

CHECKLIST OF CONCERNS (continued)

- **Legal matters, charges, lawsuits**
- **Loneliness**
- **Marital conflict, specify: ___distance/coldness, ___infidelity/affairs, ___due to remarriage**
- **Memory problems**
- **Menstrual problems, PMS, menopause**
- **Mood swings**
- **Motivation, laziness**
- **Nervousness, tension**
- **Obsessions, compulsions (thoughts or actions that repeat themselves)**
- **Oversensitivity to rejection**
- **Panic or anxiety attacks**
- **Perfectionism**
- **Pessimism**
- **Pornography, masturbation that seems out of control**
- **Procrastination, work inhibitions, laziness**
- **School problems**
- **Self-centeredness**
- **Self-esteem issues**
- **Self-neglect, poor self-care**
- **Sexual issues, unwanted same-sex desires**
- **Sexual issues, dysfunctions, conflicts**
- **Shyness, oversensitivity to criticism**
- **Sleep problems, specify ___too much, ___too little, ___insomnia, ___nightmares**
- **Smoking, specify ___tobacco, ___marijuana**
- **Stress, stress disorders, tension**
- **Suspiciousness**
- **Suicidal thoughts**
- **Temper problems, self-control, low frustration tolerance**
- **Thought disorganization and confusion**
- **Threats, violence, specify ___toward you, ___from you toward others**
- **Weight and diet issues**
- **Withdrawal, isolating**
- **Work problems, specify ___unemployment, ___workaholism / overworking, ___can't keep a ob**

Any other Concerns or Issues:

Please look back over the concerns you have checked off and choose the one you most want help with. It Is:

_____

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SECTION VII: YOUR MEDICAL HISTORY

Please list any significant past or current health or medical issues

Dates	Problem & Treatment	Were you hospitalized (Y/N)

Have you ever had treatment by, or are you currently seeing, a psychologist, psychiatrist, or other counselor? ___Yes ___No

Problem	Professional's Name (Doctor, Counselor)	When?	If Current, Telephone

Have you ever been given a mental health diagnosis in the past from a mental health professional? ___Yes ___No
If yes, as you understand it, what was the diagnosis?

MEDICATIONS USED:
If applicable, please list all medications you are now taking or have taken in the past 3 months:

Medication	Dosage	Person Prescribing	How Long Have You Been Taking?	Helpful? (Y/N)

YOUR FAMILY OF ORIGIN PSYCHOLOGICAL PROBLEMS [father, mother, grandfather, grandmother]

Have any members of your family had problems with:
drugs, alcohol depression anxiety other mental illness (specify) sexually abused sexual abuser

Who:	Problem:	Comments:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____