1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136
www.insideoutqc.com

Intake

Name & Identifying Information

Clients Name: ______________________________ Date of birth: ______________________

Relationship Status: __________________________ Employment Status: _________________

Gender: _____________ SSN: _________________ Referred By: ________________________

Address: ____

Phone Number: ____________________________ Email: ____________________________

Emergency Contact: _________________________ Emergency Phone: __________________

Please INITIAL at least TWO forms of communication we can use to touch base with you:

Phone ________ Text ________ Email ________

How would you like to be notified about appointments? ▢ Phone Call ▢ Text ▢ Email ▢ None

Insurance Information

Primary Insurance: ____

ID Number: _______________________________ Group Number: ____________________

Policy Holder Name: _________________________ Phone Number: ____________________

Address: _________________________________ Date of birth : _____________________

Relationship to Client: _______________________ Employer: _________________________

Secondary Insurance: ____

ID Number: _______________________________ Group Number: ____________________

Policy Holder Name: _________________________ Phone Number: ____________________

Address: _________________________________ Date of birth : _____________________

Relationship to Client: _______________________ Employer: _________________________

Signature: _______________________________ **Date:** _____________________________

Presenting Problems & Concerns for (Client Name): ______________________________

What are the chief concern(s) that brought you here today?

- ❏ Mood
- ❏ Anxiety
- ❏ Relationships
- ❏ Employment
- ❏ Memory
- ❏ Concentration
- ❏ Substance Use
- ❏ Medical Issue
- ❏ Recent Event
- ❏ Other: ______________________________

Please explain your concern: ______________________________

____

How would you explain your current mood? (Check all that have applied in the last 30 days)

- ❏ Happiest I've ever been
- ❏ Elated, overjoyed
- ❏ Cheerful, happy
- ❏ Tranquil, at peace
- ❏ Stable, normal, positive
- ❏ Indifferent, uninterested
- ❏ Dour, stubborn
- ❏ Depressed, very unhappy
- ❏ Hopeless, desperate
- ❏ Suicidal
- ❏ Panicky
- ❏ Fearful
- ❏ Anxious
- ❏ Apprehensive
- ❏ Worried
- ❏ Calm
- ❏ Irritable
- ❏ Angry
- ❏ Enraged
- ❏ Other: ______________

What stressors or life changes have you experienced recently? (Check all that apply)

- ❏ Finance
- ❏ Housing
- ❏ Conflict
- ❏ Work
- ❏ Loss(es)
- ❏ Medical
- ❏ Transitions
- ❏ Legal
- ❏ Other: ______________

Please explain: ______________________________

____

How would you describe your ability to cope at this time? (Check all that apply)

- ❏ Extremely resilient
- ❏ Improving
- ❏ Normal or average
- ❏ Exhausted or worn down
- ❏ Overwhelming or unable to cope

How would you describe your attitude toward therapy? ______________________________

Please explain: ______________________________

____

Have you seen a therapist or received any type of mental health treatment in the past?

- ❏ Outpatient Counseling
- ❏ Medication
- ❏ Psychiatric Hospitalization
- ❏ Drug/Alcohol Treatment
- ❏ Support Groups
- ❏ Other: ______________

Please detail your past mental health treatment below.

Reason for Treatment	Provider/Program	When?	Did it help?

Medication & Substance Use Information for (Client Name): ___________________________

What are your current medications? (Please list over the counter and prescription drugs)

Medication & Purpose	Dosage	Use as prescribed?	Do you have side effects?	Is it helpful?

Please tell us about your alcohol, tobacco, and drug use.

How many alcoholic drinks do you consume in an average week? ___________________________

Which statement best describes your alcohol use?

- ❏ I am a non-drinker
- ❏ I am in recovery
- ❏ I drink occasionally
- ❏ I drink socially
- ❏ I drink regularly
- ❏ I am a heavy drinker
- ❏ I am an alcoholic
- ❏ For how long? ________

Have you had withdrawal symptoms when trying to stop use of alcohol? _____________________

Do you use tobacco? ______________ How much? ___________________ What kind? ____________

Which statement best describes your tobacco use?

- ❏ I don't use tobacco
- ❏ I use tobacco occasionally
- ❏ I use tobacco socially
- ❏ I use tobacco regularly
- ❏ I use tobacco heavily
- ❏ For how long? ________

Are you trying to stop using tobacco? _________________ What method? _____________________

What type of drugs have you used in the last year? ____

Which statement best describes your drug use?

- ❏ I do not use drugs
- ❏ I am in recovery
- ❏ I use occasionally
- ❏ I use recreationally
- ❏ I use regularly
- ❏ I use heavily
- ❏ I am an addict
- ❏ For how long? ________

Have you had withdrawal symptoms when trying to stop using a substance? ________________

Do you feel you have problems with prescription drugs? ____________________________________

Have you ever received substance abuse treatment? _______________________________________

If so, where? ____ When? ____________________________

Did you complete the program? ________________________ How long were you sober? _________

Physical, Social & Occupational Status for (Client Name): ______________________________

Which statement best describes your physical health?

- ❑ I am generally healthy
- ❑ I have an active infection
- ❑ I have a chronic illness
- ❑ I have, or had cancer
- ❑ I have a sensory deficit (Impairment)
- ❑ I have a cold or the flu
- ❑ I recently had surgery
- ❑ I am in pain or deal with chronic pain
- ❑ Other: _______________

Have you ever had a head injury? __________ If so, please explain: __________________________

____

Please list any health issues and diagnoses: ____

____

____

Is there any other personal health information you would like us to know about? ____________

____

Do you exercise? ___________________________ How Often? __________________________________

I consider myself:

- ❑ Active
- ❑ Fit
- ❑ Average
- ❑ Inactive
- ❑ Lethargic

How many hours a night do you sleep? ______ Do you suffer from insomnia?_______________

How would you describe your social activity and are you happy with it? ____________________

- ❑ Nonstop
- ❑ Highly active
- ❑ Involved
- ❑ Occasional
- ❑ Rare
- ❑ Isolated

Please describe your social network: (Check all that apply)

- ❑ Spouse
- ❑ Nuclear Family
- ❑ Extended Family
- ❑ Close Friend
- ❑ Group of Friends
- ❑ Church/Mosque/Temple
- ❑ 12 Step
- ❑ Service System
- ❑ Other: _______________

What is your occupation? __________________ How long have you had this position? _________

Are you satisfied with your occupational situation? ____

How many hours per week do you work? ____

Which situation best describes your occupational status?

- ❑ I am a workaholic
- ❑ I am overworked
- ❑ I work full-time
- ❑ I work part-time
- ❑ I work sporadically
- ❑ I am in school
- ❑ I am unemployed
- ❑ It is hard for me to work
- ❑ I am retired
- ❑ I am a stay-at-home parent or spouse

Do you have military experience? ___________ Are you currently serving? ___________________

Branch: _______________________ Date of discharge: ______________ Rank: ___________________

Type of Discharge: _____________ Deployments: ____

What do you do for fun, hobbies, or sports? ____

Which best describes your time spent on these things?

- ❑ Too much, obsessive
- ❑ A great deal
- ❑ Good balance of work/play
- ❑ Occasional
- ❑ Rarely
- ❑ Never

Helping Us Understand You, (Client Name): ____

Are you experiencing any of the following problems or stressors?

- ❏ Abandonment
- ❏ Abuse
- ❏ Affair
- ❏ Alcohol
- ❏ Alienation
- ❏ Anger
- ❏ Anorexia
- ❏ Anxiety
- ❏ Appetite
- ❏ Avoidant
- ❏ Blended family
- ❏ Body image
- ❏ Bonding
- ❏ Boundaries
- ❏ Bulimia
- ❏ Child care
- ❏ Codependency
- ❏ Compulsions
- ❏ Conduct Problems
- ❏ Crisis
- ❏ Delusions
- ❏ Denial
- ❏ Depression
- ❏ Disability
- ❏ Disorganized
- ❏ Distractible
- ❏ Divorce
- ❏ Drugs
- ❏ Elder care
- ❏ Employment problems
- ❏ Emptiness
- ❏ Enabling
- ❏ Family conflict
- ❏ Fear
- ❏ Grades
- ❏ Grief
- ❏ Guilt
- ❏ Hallucinations
- ❏ Hyperactivity
- ❏ I feel isolated
- ❏ I want to isolate
- ❏ Idealization
- ❏ Inactivity
- ❏ Inattention
- ❏ Inhibition
- ❏ Impulsivity
- ❏ Irritability
- ❏ Jealousy
- ❏ Legal problems
- ❏ Marital problems
- ❏ Medical issues
- ❏ Memory loss
- ❏ Mood swings
- ❏ Obesity
- ❏ Obsessions
- ❏ Oppositional behaviors
- ❏ Overly dramatic
- ❏ Pain
- ❏ Panic
- ❏ Racing thoughts
- ❏ Rage
- ❏ Rationalization
- ❏ Rejection
- ❏ Relationships
- ❏ Self-absorption
- ❏ Self-esteem
- ❏ Separation anxiety
- ❏ Sexual abuse
- ❏ Shame
- ❏ Sibling conflict
- ❏ Sleep problems
- ❏ Social skills
- ❏ Something is holding me back
- ❏ Stress
- ❏ Trauma
- ❏ Trust problems
- ❏ Unexplained physical problems
- ❏ Worry

How would you describe your positive characteristics, strengths, skills, and talents? __________

____

Have you recently been physically hurt or threatened by someone? If yes, please explain: _____

____

Have you ever had feelings or thoughts that you don't want to live? ________________________

If yes, how often and did anything happen to make you feel this way?: ______________________

____

On a scale of 1 to 10 how strong is your desire to kill yourself now and would anything make it better? ____

Have you ever thought about how you would kill yourself and is that method readily available? ____

Have you ever planned a time for this and would anything stop you? _______________________

____

Understanding You Continued (Print Name) ______________________________

Have you ever attempted to kill yourself before? If so, when? ______________________

Do you feel hopeless and/or worthless? ______________________________

Do you have access to guns? If so, please explain: ______________________________

Have you ever had thoughts, made statements or attempted to hurt someone else? If yes, please describe: ______________________________

____

On a scale of 1 to 10, how strong is your desire to kill someone else currently? __________

Have you ever thought about how you would kill someone else? If so, is the method readily available? ______________________________

Have you planned a time for this or made an attempt? If so, when? __________________

Have you ever experienced the following types of trauma or loss? (Check all that apply)

- ❏ Emotional abuse
- ❏ Sexual abuse
- ❏ Physical abuse
- ❏ Neglect
- ❏ Parent substance abuse
- ❏ Teen pregnancy
- ❏ Violence in the home
- ❏ Crime victim
- ❏ Parent illness
- ❏ Place a child for adoption
- ❏ Lived in a foster home
- ❏ Multiple family moves
- ❏ Homelessness
- ❏ Loss of a loved one
- ❏ Financial problems
- ❏ Miscarriage/stillborn
- ❏ Combat or war zone
- ❏ Natural disaster
- ❏ House fire

Please note anyone between you or your family that experienced any mental health problems

	ADHD			Postpartum Depression	
	Physical Abuse			Emotional/Verbal Abuse	
	Sexual Abuse			Depression	
	Bipolar Disorder			Suicide Attempt or Completion	
	Anxiety			Panic Attacks	
	OCD			Anger/Abusive Behavior	
	Schizophrenia			Eating Disorder	
	Alcohol Abuse			Autism	
	Self-Harm Behaviors			Other:	

Please check all that apply to your childhood

- ❏ Happy childhood
- ❏ Physically abused
- ❏ Weight problems
- ❏ Family fights
- ❏ Drug or alcohol use
- ❏ Depressed
- ❏ Anxious
- ❏ Not allowed to grow up
- ❏ Neglected
- ❏ Few friends
- ❏ Popular
- ❏ Poor grades
- ❏ Good grades
- ❏ Spoiled
- ❏ Forced to grow up "too fast"
- ❏ Adopted at ______ (age)
- ❏ Sexually abused
- ❏ Parents divorced
- ❏ Behavior problems in school
- ❏ Sexual problems
- ❏ Anger problems
- ❏ Attention problems
- ❏ Moved frequently

Understanding You Continued (Print Name): ____________________

Where did you grow up? ____________________

What was your father's occupation? ____________ Mother's? ____________

Did your parents divorce? If so, how old were you and who did you live with? ____________

____

Describe your father and your relationship with him ____________________

____

Describe your mother and your relationship with her ____________________

____

How old were you when you left home? ____________________

Has anyone in your immediate family died? If so, who and when? ____________

____

Education

Are you currently a student? If yes, where do you go to school? ____________

Do you feel school is a struggle for you? ____________________

What is the highest level of education you completed? ____________

If you have a college degree, what was your area of study? ____________

Relationship History and Current Family Situation

Marital Status: ____________ If unmarried, are you in a relationship? ____________

If yes to either, how long? ________ What is your sexual orientation? ____________

Are you sexually active? ________ If yes, are you satisfied with your sex life? ________

Are you currently involved in any divorce or child proceedings? If yes, please explain: ________

____

What is your spouse's occupation? ____________________

Describe your relationship with your significant other: ____________________

Have you had any prior marriages? If so, how many and when? ____________

Have you been in a relationship that involved domestic violence? If so, when? ________

Are you or your partner experiencing any infertility issues? If so, for how long? ________

Do you have any children? If yes, tell us about them: ____________________

____

Who else currently lives with you? (Name, Age, Gender, Relationship) ____________

____

Have you ever been arrested or convicted? If yes, please explain ____________

Do you have any legal problems? If yes, please explain ____________

Signature: ____________________ **Date:** ____________

1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136
www.insideoutqc.com

FINANCIAL AGREEMENT

***Please initial each of the following statements agreeing to our policies.* _____**
Payment for copay, co-insurances, deductible or out of pocket fees are due at the time of service. We accept private pay and some insurance plans. Cash, check, Visa, MasterCard, HSA are accepted. A credit card is required to have on file for each visit to ensure office efficiency but you may still use a different form of payment at the time of service. This form authorizes Inside Out Counseling & Consulting to charge outstanding balances to the credit card you provide us. If paying with a check, please make it payable to Inside Out Counseling & Consulting. A $10.00 service charge will be added for any checks returned for any reason. If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility it could later be denied. In this event, you are responsible for the full payment balance.

MISSED APPOINTMENT POLICY

_____ If you are unable to keep an appointment, you must notify me by phone (563-424-6120) or email (insideoutqc@gmail.com). Appointments must be cancelled **at least 24 hours prior** to your appointment; otherwise, your account will be charged a **$60** late cancellation fee. If you **fail to show** for your appointment without notice, your account will be charged the **full session fee**. If you are 15 minutes or more late to your appointment then that session will be canceled. If no contact was made with the provider about late attendance or the need to cancel then this will count as a **no call no show** and your account will be charged the **full session fee**. All fees will be due and payable by your card on file. You must acknowledge and approve this transaction. In the event of extremely bad weather such as ice and snow, please call the office to confirm office hours.

LEGAL/PROFESSIONAL FEES

_____ There may be charges for questionnaires or letters that are not normally required for billing or treatment purposes, including but not limited to lengthy phone consults, or medical record requests. You are agreeing to not depose me by signing this Consent Form; but should I be ordered to testify, there will be a fee of no less than $950. The $950 reserves a maximum of a 4-hour block. The minimum block to reserve after the initial 4 hours is another 4 hours at the same rate. This is non-refundable when reserved and also payable at the time of reserve for me to clear my schedule for your case for any legal deposition or court testimony or proceedings or meetings. Expenses I may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at an appropriate rate and are in addition to the minimum $950. My fee for matters involving the courts, included but not limited to reviewing case files, consultations with attorneys and/or patients, or preparation for court matters by court order, will be assessed at $225 per hour with a minimum of 2 hours, which is non-refundable.

INSURANCE

_____ If you choose to utilize your insurance, I will file your claim as a courtesy. You are ultimately responsible for the charges. If claims are denied due to lack of coverage then you are responsible for the charges. You may choose to avoid insurance and privately pay by waiving right to file. If I am out-of-network with your insurance you can be provided with a superbill to submit to your insurance for possible reimbursement.

DELINQUENT ACCOUNTS

_____ In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees. The account will become delinquent after it has matured to 60 days from the date of service. Once in collections, there will be an added 25% to the account balance plus incurred legal fees. The office of Inside Out Counseling & Consulting will determine the collection agency.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name: ________________________________ Date: ________________________________

Signature: ____

Parent/Legal Guardian:
Print Name: ________________________________ Date:

________________________________ Signature:

____

Provider Signature: ____________________________ Date: ____________________________

1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136
www.insideoutqc.com

INFORMED CONSENT FOR PSYCHOTHERAPY

Please initial each of the following statements agreeing to our policies. The therapeutic relationship is unique in that it is highly personal but also, a contractual agreement. It is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read, initial and sign indicating that you have reviewed this information and agree to it. Thank you.

THE THERAPEUTIC PROCESS

_____ You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY

_____ The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse or neglect of children under the age of 18 years or an elderly person.
4. If a court of law issues a subpoena for information stated on the subpoena. 4. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize that. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Name: ________________________________ Date: ________________________________

Signature: ____

Parent/Legal Guardian:
Print Name: ________________________________ Date:

________________________________ Signature:

____

Provider Signature: ____________________________ Date: ____________________________

1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136
www.insideoutqc.com

Credit Card Authorization

Our office requires that a card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to this information. If possible, please print this and bring along with your paperwork to your first appointment.

Patient Name: ____

Name, as it appears on card: ____

Billing Address: ____

Email Address: ____

Signature of card holder: ____

Date: ____

--------------------------------------cut this portion off and shred after encryption --------------------------

Amex/Disc/MC/Visa Card Number: ____

Expiration Date: ____

Verification Code: ____

1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136
www.insideoutqc.com

Authorization to Obtain, Disclose and Exchange PHI

Clients Name: ______________________________ Date of birth: __________________

Legal Guardian's Name (if applicable): ____

Relationship to Client: ▢ Self ▢ Parent/Guardian ▢ Representative ▢ Other: _____________

AUTHORIZATION: The undersigned hereby authorizes Inside Out Counseling & Consulting to obtain from, disclose to, and exchange protected health information either orally or in writing.

Name/Agency: ______________________________ Phone Number: ______________

Address: ____

Email: _____________________________________ Fax Number: ________________

INFORMATION: I authorize the following PHI to be obtained, disclosed, and exchanged. ▢ Progress notes ▢ Information related to developmental history ▢ Notes of participation and/or social history

▢ Treatment plan ▢ Information related to medical history/evaluations ▢ Treatment/Closing summary ▢ Information related to educational records ▢ Mental health evaluations/recommendations

▢ Other: ____

PURPOSE: The above information will be used to facilitate effective treatment service coordination and for the following purposes:

▢ Planning appropriate treatment/program ▢ Case review

▢ Continuing appropriate treatment/program ▢ Updating files

▢ Determining eligibility for benefits/program ▢ Other: ____________________________

SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION BY STATE & FEDERAL LAW I acknowledge that the information to be disclosed may include material that is protected by Federal and/or State Law applicable to substance abuse, mental health and AIDS. Please initial by the ones that apply: _____ Substance Abuse _____ Mental Health Information _____ Aids-related information

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

Clients Signature: ______________________________ Date: __________________

Legal Guardian's Name (if applicable): ____

Provider/Clinician Signature: _______________________ Date: __________________