1938 E. Lincoln Highway, Suite 219, New Lenox IL 60451

Phone: 815-320-3749/Fax: 815-320-3825

Client Intake Information

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis Code: \_\_\_\_\_\_\_\_\_ (Office Use Only)

Primary Insurance Policy Information:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Relationship to the Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Secondary Insurance Policy Information:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Relationship to the Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Are you utilizing EAP services? If so, what is the name of EAP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/insurance benefits to myself or to The Kennedy Center for Counseling*.*

I authorize payment of medical benefits to The Kennedy Center for Counseling for services provided.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# The Kennedy Center for Counseling

*1938 E. Lincoln Highway, Suite 219, New Lenox IL 60451*

*Phone: 815-320-3749 fax: 815-320-3825*

**Notice of Privacy Practices - Summary**

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

## Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. Though these laws are complicated, we must provide you with this important information. These two pages summarize the Notice of Privacy Practices which you received along with this. You may refer to the complete document for more information. We realize that it is not possible to cover all scenarios in this document, so please consult our Privacy Officer, Owner Rita Sanders if you have further questions or concerns.

The health information we will obtain will be documented primarily from you, but may also include information obtained from other family members or professionals involved in your case that you have given us permission to speak with. This information will be used to provide you with effective treatment, to arrange payment for our services or for other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a form acknowledging that you have received this notice. If you are not willing to sign this form, we cannot treat you.

If information regarding your treatment here needs to be disclosed to others for family involvement or for coordination of treatment services we will discuss this with you and ask you to sign an Authorization to allow this.

We will keep all of your health information private. However, there are some situations where the law requires us to disclose information about you even without your signed consent, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

1. Some lawsuits and legal or court proceedings.

1. If a law enforcement official requires us to do so.

1. For Workers Compensation and similar benefit programs.

See the complete text of the NPP for the full list of mandated disclosure scenarios.

## Your rights regarding your health information

1. You have the right to determine how we get in touch with you if we need to (for appointment changes or cancellations). Let us know if you prefer us to call your home or your cell and whether it is okay to leave a message.

1. You have the right to determine what information is shared with others involved in your treatment.

1. You have the right to review your record, and can request a copy of your record (medical and billing).

1. If you believe the information in your records is incorrect or incomplete, you can request that changes or amendments be made to them. This request must be made in writing, and must include reasons for the request.

1. You have the right to receive a copy of this notice. If our Privacy Practices are changed, we will post a notice in our waiting room and a copy can be requested.

1. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies,

please contact our Privacy Officer, Rita Sanders, phone number 815-320-3749, 1938 E. Lincoln Highway, Suite 219, New Lenox IL 60451.

The effective date of this notice is April 14, 2003

## Notice of Privacy Practices: Receipt and Acknowledgment of Notice

### Patient/Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of The Kennedy Center Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Rita Sanders, 815-320-3749.

**I also verify that I understand the following**:

All the information in my sessions is confidential **EXCEPT:**

**If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused, then the therapist must tell someone to protect me or another.**

**CONSENT TO TREATMENT**

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by The Kennedy Center providers.

### I understand and agree to the above provisions

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient/Client Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature or Parent, Guardian or Personal Representative Date**

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

**Patient/Client Refuses to Acknowledge Receipt**:

Signature of Staff Member Date

# The Kennedy Center for Counseling

# 1938 E. Lincoln Highway, Suite 219, New Lenox, Il 60451

# Phone: 815-320-3749 fax: 815-320-3825

**Consent to release information to Primary Care Physician**

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name Date of Birth Patient Social Security #

Please check one:

□ I agree to allow my Kennedy Center therapist to release mental health/substance abuse information to my Primary Care Physician.

□ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

## Information for PCP

This patient was seen by me on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for (diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Printed Name

The Kennedy Center for Counseling

Marital History

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Age\_\_\_\_\_

Spouse’s Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_

Marriage Date\_\_\_\_\_\_\_\_\_\_\_\_\_ My marriage is **□**Great **□**Good **□**OK **□** Fair **□** Poor

Number of marriages\_\_\_\_\_\_\_\_\_\_\_

Strength’s of your present marriage

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Problems of your present marriage

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Children: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Employment

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long employed ? \_\_\_\_\_\_

What (if any) problems do you have with your employment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Military Service?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrests **Y N** Convictions **Y N** Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Symptom Check List

Please check all that apply

□ Financial difficulties □ Legal Problems □ Depression □Anxiety

□ Voices in my head □ Suicidal thoughts □Attempts □ Crying spells

□ Difficulty with relationships □ Loneliness □Anger □ Loss of appetite

□ weight gain □ weight loss □ Eating disorder □ Self abuse □ Mood Swings

□ Memory loss □ Agitation □ Mental Illness □I have thought of hurting myself

□ I have thought of hurting someone else □Previous psychiatric hospitalization

□Previous Mental Health Treatment

With whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Helpful? Y N

Medications you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Anything else you think your therapist should know

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The Kennedy Center for Counseling

**Alcohol & Drug Screen Questionnaire**

1. Do you feel you are a normal drinker? (“normal” – drink as much or less than most other

people) **YES NO**

1. Have you ever awakened the morning after some drinking the night before and found you

could not remember a part of the evening? **YES NO**

1. Does any near relative or close friend ever worry or complain about your drinking? **YES NO**

1. Can you stop drinking without difficulty after one or two drinks? **YES NO**

1. Do you ever feel guilty about your drinking?  **YES NO**

1. Have you ever attended a meeting of Alcoholics Anonymous (AA)? **YES NO**

1. Have you ever gotten into physical fights when drinking?  **YES NO**

1. Has drinking ever created problems between you and a near relative or close friend? **YES NO**

1. Has any family member or close friend gone to anyone for help about your drinking? **YES NO**

1. Have you ever lost friends because of your drinking? **YES NO**

1. Have you ever gotten into trouble at work because of drinking?  **YES NO**

1. Have you ever lost a job because of drinking?  **YES NO**

1. Have you ever neglected your obligations, your family, or your work for two or more days in a

row because you were drinking? **YES NO**

1. Do you drink before noon fairly often? **YES NO**

1. Have you ever been told you have liver trouble such as cirrhosis? **YES NO**

1. After heavy drinking have you ever had delirium tremens (D.T.’s), severe shaking, visual or

auditory (hearing) hallucinations? **YES NO**

1. Have you ever gone to anyone for help about your drinking? **YES NO**

1. Have you ever been hospitalized because of drinking?  **YES NO**

1. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?  **YES NO**

1. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help

with any emotional problem in which drinking was a part of the problem?  **YES NO**

1. Have you been arrested more than once for driving under the influence of alcohol?  **YES NO**

1. Have you ever been arrested, even for a few hours, because of other behavior while drinking?  **YES NO** (if Yes, how many times\_\_\_\_\_\_\_\_)

**Alcohol & Drug Use**

At what age did you have your first drink? \_\_\_\_\_\_ At what age did you first try a drug? \_\_\_\_\_

Current use: alcohol – frequency \_\_\_\_ daily \_\_\_\_ weekly \_\_\_\_monthly \_\_\_\_ none

amount each episode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

drugs – frequency \_\_\_\_\_ daily \_\_\_\_weekly \_\_\_\_ monthly \_\_\_\_\_ none

drug of choice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check any of the following that you have experimented with or used:**

Barbiturates (downers) \_\_\_\_\_ Tranquilizers (Valium, Xanax, etc)\_\_\_\_\_ Sleeping Pills\_\_\_\_\_

Amphetamines (uppers) \_\_\_\_\_ Marijuana \_\_\_\_\_ Cocaine \_\_\_\_\_

Hallucinogens (LSD, STP, PCP) \_\_\_\_\_ Opiates (heroin, morphine, Demerol) \_\_\_\_\_

Ecstasy \_\_\_\_\_ Inhalants \_\_\_\_\_ other drugs \_\_\_\_ Over the counter medications \_\_\_\_\_



The Kennedy Center for Counseling

1938 E. Lincoln Highway, Suite 219  New Lenox, 60451  
Phone: 815-320-3749 Fax: 815-320-3825

Cancelation Policy

**I verify that I understand the following**:

**CREDIT CARD REQUIRED**- **All patients** are required to keep a current valid credit card on file with us at all times. In the event you fail to give our office 24 hour cancellation notice, your credit card will be charged with a fee of $50.00. The Kennedy Center may also charge your credit card if your account balance is delinquent for any outstanding balances not paid within 2 billing periods after receiving. **\_\_\_\_\_\_\_\_ Initial**

**CANCELLING APPOINTMENT-** We ask every patient to be courteous and respectful of others needs and therefore, we require at least a 24 hour notice in canceling your appointment. **\_\_\_\_\_\_\_\_ Initial**

**INSURANCE DOES NOT COVER LATE CANCEL NO SHOW APPOINTMENTS**

IF YOU HAVE A FAMILY EMERGENCY- BRING A COPY OF YOUR ER VISIT OR URGENT CARE VISIT TO YOUR NEXT APPOINTMENT SO THE FEE MAY BE WAIVED.

**Payment at time of service** is expected unless other arrangements have been made.

**\_\_\_\_\_\_\_\_ Initial**

**Health insurance** If health insurance covers my sessions, The Kennedy Center for Counseling will help me seek reimbursement from the insurance company. **ANY** unpaid balance after insurance is **MY** responsibility to pay. I agree that The Kennedy Center may release to my insurance company any information needed to secure payment for service. **\_\_\_\_\_\_\_\_ Initial**

**Unpaid account balances** If I do not pay my account balance after receiving two notices of the delinquency, I understand that my account may be charged to my credit card or turned over to collections. **\_\_\_\_\_\_\_\_ Initial**

**Insufficient funds** In the event that any check I write is returned NSF (insufficient funds) I agree to pay a $15.00 Service Fee. **\_\_\_\_\_\_\_\_ Initial**

**I understand and agree to the above provisions**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient/Client Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature or Parent, Guardian or Personal Representative Date**

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member Date



**Authorization to Use Credit Card**

I Authorize The Kennedy Center for Counseling, P.C to keep my signature on file and to Charge my credit, debit or HSA Card for:

\_\_\_\_ Monthly balance of charges due by patient and/or guarantor.

\_\_\_\_ Recurring charges of $\_\_\_\_ weekly/monthly for required co-payments.

I understand that this form is valid only during the terms of my treatment services at The Kennedy Center.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Credit Cardholder Name and Address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Credit Card Account Number:** \_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_

**Card Expiration Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**3Digit Security Code:** \_\_\_\_\_\_\_\_\_\_

**Printed Name of Cardholder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardholder’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_