Intake Questionnaire For New Patients/Clients

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Social Security Number**:_____-____-_____

Name: _____

Address: _____ **Date of Birth**: _____ **Age:** _____

_____ **City/State/Zip code**: _____

Home Phone: _(_____) _____-_____

Emergency Contact Name: _____ **Cellular/Alternate Phone**: _(_____) _____-_____

Relationship To You: _____

Marital Status: Single Married Separated Divorced
Re-Married Engaged Widowed Co-Habiting

If applicable, please complete the following: Partner's/Spouse/ Significant Other's Name: _____ **Partner's Age**: _____

What is their Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____

_____

_____

_____

_____

How long has this been going on? _____

How will you be paying for services? Out of Pocket _____ **Insurance** _____

Primary Insurance Company Name: _____ **Member ID #:** _____

Insurance Company Phone #: (_____) _____ - _____ **Group #:** _____

Primary Insured's Name:_____ **Primary Insured's Date of Birth:** _____/_____/_____

Relationship to You: _____

Secondary Insurance Company Name: _____

Member ID #: _____ **Group #:** _____

Insurance Company Phone #: (_____) _____ - _____

Secondary Insured's Name: _____ **Secondary Insured's Date of Birth:** ___ / ___ / ____

Relationship to You: _____

How did you hear about us? _____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

_____

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger
- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person
- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.
- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else
- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or the radio is communicating with you
- ☐ Difficulty problem solving
- ☐ Difficulty meeting role expectations
- ☐ Dependency on others
- ☐ Manipulation of others to fulfill your own desires
- ☐ Inappropriate expression of anger
- ☐ Self-mutilation/cutting
- ☐ Difficulty or inability to say "no" to others
- ☐ Ineffective communication
- ☐ Sense of lack of control
- ☐ Decreased ability to handle stress
- ☐ Abusive relationship
- ☐ Difficulty expression emotions
- ☐ Concerns about your sexuality

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

☐ No ☐ Yes If so:

Name of therapist: _____ Dates of Treatment

Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment

Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment

Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

MEDICAL HISTORY ****INCLUDE PAST AND PRESENT MEDICAL HISTORY****

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

THIS WOULD INCLUDE PRIMARY CARE PROVIDERS, SPECIALTY PROVIDERS SUCH AS NEUROLOGIST, PAIN MANAGMENT, ECT.

_____

_____

_____

_____

List any PRIOR illnesses, operations and accidents

_____

_____

_____

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased Cause of death:_____
If deceased, HIS age at time of his death____ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: ☐ Living ☐ Deceased Cause of death:_____
If deceased, HER age at time of his death___ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				☐ No	☐ Yes
				☐ No	☐ Yes
				☐ No	☐ Yes
				☐ No	☐ Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ No ☐ Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship to you:_____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously?_____ If Yes, please describe: _____

When?_____ How long? _____
When?_____ How long? _____

Education

Highest grade level completed: _____
Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades did you get in school? _____

Have you served in the military? _____
If yes, please describe briefly: _____
_____

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____
If yes, employer's name: _____
What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____
If yes, please describe: _____

Do you have a religious affiliation? _____
If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____
_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use _____
How much do you drink? _____
How often do you drink? _____
Have you ever passed out from drinking? _____ How often? _____
Have you ever blacked out from drinking? _____ How often? _____
Have you ever had the "shakes"? _____ How often? _____
Have you ever felt you should cut down on your drinking/drug use? _____
Have people annoyed you by criticizing your drinking/drug use? _____
Have you ever felt bad or guilty about your drinking/drug use? _____
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____
Do you use tobacco? _____
If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	**EXPERIENCED, YES**	**NO**
Death of Spouse		
Divorce		
Marital Separation		
Gone to jail		
Death of close family member		
Personal injury or illness		
Marriage		
Fired at work		
Marital reconciliation		
Retirement		
Change in health of family member		
Pregnancy		
Sexual Difficulties		
Gain of new family member		
Business readjustment		
Change in financial state		
Death of a close friend		
Change to different line of work		
Increase in arguments with spouse		
Mortgage over $100,000		
Foreclosure of mortgage or loan		
Change in responsibilities at work		

Life Events	**EXPERIENCED, YES**	**NO**
Son or daughter leaving home		
Trouble with in-laws		
Outstanding personal achievement		
Spouse begins or stops work		
Begin or end school		
Change in living conditions		
Revision in personal habits		
Trouble with boss		
Change in work hours or conditions		
Change in residence		
Change in schools		
Change in recreation		
Change in church activities		
Change in social activities		
Mortgage or loan less than $30,000		
Change in sleeping habits		
Change in number of family get-togethers		
Change in eating habits		
Vacation		
Christmas alone		
Minor violations of the law		

Authorization for Services with Informed Consent

I, _____, hereby authorize the staff of Flagler Mental Health Center INC./ Blue Water Wellness Center to administer such medical, diagnostic, and/or therapeutic interventions as considered necessary for my treatment. Recommendations for treatment will be discussed with me by the evaluating staff member as indicated.

I understand that all communication between me and Flagler Mental Health Center INC./ Blue Water Wellness Center staff will be treated as strictly confidential and no information will be released without my written permission. However, I also fully understand and accept that there are exceptions to confidentiality that are either mandated or implied by Florida law and that confidentiality may be breached if:

1. There is cause to suspect that the person served is the victim of abuse.
2. There is cause to suspect that the person served is the perpetrator of abuse.
3. There is cause to suspect that the person served poses a risk of imminent harm to self or others.
4. The person served becomes involved in the commission of a felony.
5. The person served files a civil or criminal law suit against employees of Flagler Mental Health Center arising out of services received from Flagler Mental Health Center INC./Blue Water Wellness Center
6. Flagler Mental Health Center INC./ Blue Water Wellness Center staff is compelled to testify or release information pursuant to a valid court order.

I have read and full understand this Authorization for Services. No guarantee or assurance has been made to me regarding results that may be obtained.

I attest that I have received a handbook which includes information regarding Flagler Mental Health Center INC./Blue Wellness Center, as well as information about handling emergencies, and follow-up care in case I discontinue services at Flagler Mental Health Center INC./Blue Water Wellness Center.

Client's Signature: _____

Date: _____

Patient Bill of Rights

Client Name: _____

Client ID: _____

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. A summary of your rights and responsibilities follows:

- You have the right to be treated with courtesy and respect, to be able to maintain your dignity at all times, and to maintain your need for privacy.
- You have the right to know the name, function, and qualifications of each health care provider who is providing services to you.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know who is providing medical services and who is responsible for your care.
- You have the right to know what rules and regulations apply to your conduct.
- You have the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- You have the right to refuse any treatment, except as otherwise provided by law.
- You have the right you receive upon request, prior to treatment, a reasonable estimate of charges for your treatment.
- You have the right to impartial access to treatment, regardless of race, national origin, religion, handicap, or source of payment.
- You have the right to know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
- You have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the Flagler Mental Health Center INC./Blue Water Wellness Center and to the local Substance Abuse and Mental Health Office.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Responsibilities

EACH CLIENT HAS THE FOLLOWING RESPONSIBILITIES:

- Respect the rights of other clients and staff of FMHC/BWWC.
- Honor and preserve the confidentiality of other clients.
- Be considerate of all other clients and staff.
- Keep all appointments to assure continuity of care.
- You must call to reschedule or cancel your appointment 24 hours in advanced or you will be charged the listed "no show" fee.
- To read, understand, and sign the FMHC/BWWC Discharge Policy
- Compliance with therapeutic recommendations and assignments (as applicable) is expected as part of the therapeutic process.

FEES FOR SERVICES:

Payment for services rendered is expected at time of service. Co-payments, charges applied towards deductibles and/or negotiated rates for those experiencing a financial hardship will be collected when you arrive for your scheduled appointment unless prior arrangements have been made.

Please be aware that it is your responsibility to pay for services you are requesting, but are not covered by your insurance company. These services may include (but are not limited to): expert witness testimony, reports/letters to be sent to lawyers, probation officers, courts schools, and/or other parties, and other such professional services. Fees for these services vary and must be negotiated and paid for prior to the service being rendered. Requests by phone will not be honored and a signed agreement between the provider and patient must be made in writing for any services not covered by insurance benefits.

COMPLIANCE WITH RULES AND REGULATIONS:

I hereby acknowledge that I have read and understand, or have had explained to me, the rules and regulations of Flagler Mental Health Center INC./ Blue Water Wellness Center and hereby agree to abide by them.

I also understand that non-compliance with the rules and regulations of this therapeutic program may lead to possible discharge. Upon discharge, when applicable, a letter will be sent to the referring agency stating the reason for discharge.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy of Information

Client Name: _____

Client ID:_____

I acknowledge that I have received a copy of the HIPAA Privacy of Information Notice from Flagler Mental Health Center INC./Blue Water Wellness Center. I further acknowledge that I understand who to contact in case of any needs, concerns, or to request additional copies of the notice.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Flagler Mental Health Center/Blue Water Wellness Center Client Handbook

Client Name: _____

Client ID:_____

I have received and understand the information provided to me in this handbook.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization to Obtain and/or Release Confidential Information

Medical Records Address: 2729 East Moody Blvd, Suite 105 Bunnell, FL 32110

Phone: (386) 313-1989 or (888) 212-3364
Fax: (386) 206-1057
Secure Email: info@fmhc.net

Client Name: _____ Client DOB: ___/___/_____
Client SS: _____ - ____ - _____ Client ID: _____

I hereby authorize Flagler Mental Health Center INC./Blue Water Wellness Center to release or obtain my Protected Health Information in accordance with Florida Statutes: 394, 396, 397, 381.609, 415, 455, 490, 960, and (42 CFR Part 2). I understand that this authorization extends to all or any part of the records designated, which may include: records of minors, psychiatric information, alcohol/drug abuse, TB and/or STD or documented proof of HIV testing and/or AIDS diagnosis information. A general medical authorization and subpoena duces tecum, without a specific authorization to release records as mentioned must have this waiver from the client or his/her empowered representative. **I understand this authorization extends to the release of information via US. Mail, telephone, or fax machine.**

Information may be disclosed to ☐ and / or obtained from ☐	
Name:	
Address:	
Phone:	Fax:

Prohibition of disclosure:

Alcohol, drugs, Mental Health, and/or HIV/ARC and/or AIDS diagnosis information, if present, has been disclosed from records whose confidentiality is protected by Florida State and Federal law. Federal Regulations (42CRF, part 2) prohibit making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Purpose of disclosure:

☐ Continuity of Care	☐ Client Requests Copies
☐ Lab / Pharmacy	☐ Other:

Information to be disclosed:

☐ In-Patient Records	☐ Therapist Evaluation	☐ Medication Record
☐ Psychological / Psychiatric Evaluations	☐ Dr.'s Notes	☐ Treatment Plan
☐ Substance Abuse Evaluation	☐ Substance Abuse Treatment	☐ Lab Results
☐ Mental Health Records	☐ Medication Record	☐ Discharge Summary
☐ Other (specify):		

I understand that this authorization is revocable upon written notice to FMHC/BWWC, except to the extent that action by this agency has already been taken on this authorization. This authorization shall remain in force for a reasonable time to accomplish the purpose for which it is given or will expire in 365 days (1 year), unless revoked by written notice and provided said notice is received prior to the release of the above designated information. ***Re-disclosure of this information without express permission from me is prohibited.***

Client Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____ Date:_____

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Information may be disclosed to ☐ and / or obtained from ☐	
Name of Physician:	
Address:	
Phone:	Fax:

Prohibition of disclosure:

Alcohol, drugs, Mental Health, and/or HIV/ARC and/or AIDS diagnosis information, if present, has been disclosed from records whose confidentiality is protected by Florida State and Federal law. Federal Regulations (42CRF, part 2) prohibit making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

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☐ Mental Health Records	☐ Medication Record	☐ Discharge Summary
☐ Other (specify):		

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Client Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____ Date: _____

Past Psychiatric Medications: If you have **ever** taken **any** of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, **Please write in what you do remember)**.

Antidepressants	Dates	Dosage	Response/ Side-Effects

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____
Lithium_____
Depakote (valproate) _____ _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Other _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Seroquel (quetiapine)_____
Haldol(haloperidol)_____
Prolixin(fluphenazine)_____
Risperdal(risperidone)_____
Other_____

Sedative/Hypnotics

Ambien(zolpidem)_____
Sonata(zaleplon)_____
Rozerem(ramelteon)_____
Restoril(temazepam)_____
Desyrel(trazodone)_____
Other_____

Past Psychiatric Medications: If you have **ever** taken **any** of the following medications, **please** indicate the dates, dosage, and how helpful they were (if you can't remember all the details, **please** write in what you **do** remember).

	Dates	**Dosage**	**Response/Side-Effects**

ADHD medications

Adderall(amphetamine)_____
Concerta(methylphenidate)_____
Ritalin(methylphenidate)_____
Strattera(atomoxetine)_____
Vyvanse (Lisdexamfetamine Dimesylate)_____
Daytrana(methylphenidate) _____
Other_____

Anti-Anxiety Medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____