LKH Therapy

Live In Balance • Know Your Strengths • Harness Your Power

Laura Kezdi-Hamzeloo, MA, LCPC

If you have any concerns regarding confidentiality, PLEASE discuss them prior to completing any section of this document.

DEMOGRAPHIC INFORMATION
(Please write legibly)

Name: _____ Date: _____

Address: _____ Age: _____DOB: _____

City: _____ Gender: _____ _____

State/Zip Code: _____ Cell Phone: _____

How may we contact you?

Voicemail: Y___ N ___ Text: Y ___ N ___ E-mail: Y___ N ___ Mail: Y___ N___

Email address: _____

Complete this section if utilizing insurance coverage for your sessions.

We will need a copy of your Insurance Card and Driver's License

Is the insurance coverage under your name? Y___ N___ **IF NO Please complete the information below:**

Subscriber's name: _____ DOB: _____

Address: _____ Phone_____

Relationship to the patient: _____

If you are being referred through an Employee assistance program:
Compsych please indicate reference number: _____

Employee Assistance Progam _____Phone_____

I authorize the staff at LKH Therapy to bill my insurance company for services rendered.

I understand I will be charged for any appointments cancelled without 24 hours notice.

Signature: _____ Date: _____

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COUNSELING AGREEMENT

I understand I am entering into this counseling relationship of my own free will.

I understand that I have the right to terminate at any time.

I understand the services I am receiving will be within the training and professional capabilities of my counselor.

I agree to abide by the financial agreement between LKH Therapy and myself. I understand that should my counselor feel this level of treatment is not the appropriate level of care, I will be referred to a level of care that will meet my needs. I understand if I refuse to attend or explore these options/referrals, my counselor may have an ethical duty to suspend or terminate treatment.

This counselor abides by State and Federal confidentiality law (s) {42CFR}. *I understand the only times confidentiality laws do not apply are in cases of child abuse or neglect, elder abuse or neglect and in cases where I may present as suicidal or homicidal*.

I do have a choice to sign a release allowing my counselor to speak to someone I deem appropriate. This release can be as specific as I choose. Signed releases can be rescinded at any time.

I understand that should there be a time where appointments have not been made within a period of time, which is determined on a case-by-case basis, I may receive a letter of "termination". This letter only means that you are choosing to not be an active client of LKH Therapy. You are always welcome to return to services at any time. We often have clients that utilize services on an "as needed" basis, similar to perhaps an arrangement of a general practice medical doctor.

By signing this document, I am indicating I have read and understand the contents. I have been given the opportunity to ask questions regarding this document.

Client signature/date_____

Guardian (under 18)_____

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FINANCIAL AGREEMENT
(CLINICIAN COPY)

Name of Client (Guardian)_____

Payment is due each time services are rendered. The staff at LKH Therapy will make every attempt to utilize my insurance company or employment assistance program in terms of reimbursement for services. However, should my insurance company deny benefits for any reason, I understand that I (the client) am responsible for all fees incurred. Moreover, I am of the agreement that I am responsible for any applicable copays, co-insurance and/or deductibles consistent with my insurance plan and may be required to pay fees while following up with my insurance company.

I will keep the staff at LKH Therapy updated for any change in coverage, including providing copies of a new insurance card, changes and/or updates with my credit card I may have on file, etc. insurance company. If I am utilizing EAP services, I am responsible for making sure I have authorization for services. If I have been provided an authorization number, please make this available to administrative staff. We accept credit cards, cash as well as checks. Note: that should there be insufficient funds in your checking account; you are responsible for the amount of the check and a $60 bank fee incurred by LKH Therapy.

Payment MUST be made within 30 days of my statement; it is my responsibility to follow up with any problems with funding from my insurance company or Employment assistance program. All balances in excess of 60 days past due are subject to collections. Statements are NOT routinely sent out to clients. If you should need a statement, please contact the administrative staff.

Please initial here _____FOR ALL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF THE SCHEDULED TIME, A "NO SHOW FEE" WILL BE CHARGED UP TO THE AGREED RATE REIMBURSED BY YOUR INSURANCE CARRIER OR THE AMOUNT PER SESSION FOR SELF-PAY CLIENTS. ALL NO SHOW FEES MUST BE PAID ***PRIOR*** TO YOUR NEXT APPOINTMENT.

_____ _____

Client Signature **Date**

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session

PRESENTING ISSUE

-Why did you come in today?

-How long have you been experiencing these issues?

-How have these issues been affecting you in your daily life?

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MARITAL STATUS

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

-Please list any children/age:

EMPLOYMENT STATUS

Full-time:	_____	Retired:	_____
Part-time:	_____	Homemaker	_____
Employed, not working due to extended illness	_____	Full-time student	_____
Unemployed	_____	Permanently Disabled	_____

Other (please describe):

-Occupation:

-Military Service: Yes____ No____ Describe:

EDUCATION

High School/G.E.D.: Yes_____ No_____
Last grade completed: _____
Currently attending school/grade: _____

Special training: _____
Highest Degree: _____

	Yes	No
-Did you receive special educational assistance in school?	____	____
-Were/are there any problems or concerns with performance or behavior at school/work?	____	____

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	Yes	No
-Are you experiencing financial problems?	____	____
-Were/are there any legal involvement or problems?	____	____
-Do you have any problems or concerns related to sexuality or your sexual orientation?	____	____

-Describe any exceptional childhood events (e.g., achievement, divorce, illness, adoption, trauma, etc.)

-How much support do you get from family, friends, church? (please circle)

Great deal Some Little None

-Describe current social activities (number of friends, play activities, recreational interests, and hobbies/leisure activities)?

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

-How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

-Please list any specific health problems you are currently experiencing:

-List past hospitalizations, operations or serious illnesses:

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-Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe:

-How many times per week do you generally exercise?

-What types of exercise to you participate in?

-Have you previously received any type of mental health services (psychotherapy, psychiatric services, psychiatric hospitalizations, etc.)?
□ No
□ Yes, previous therapist/practitioner/hospitalizations:

-Are you currently taking any prescription medication?
□ Yes
□ No
Please list:

-Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

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PSYCHOLOGICAL SYMPTOMS

	Yes	No
Are you currently suicidal? Do you have a suicide plan?	____	____
Suicidal thoughts only?	____	____
Previous suicide attempt at any time?	____	____
Are you currently engaged in aggressive/violent behavior?	____	____
Do you have aggressive/violent thoughts?	____	____
Have you had aggressive/violent behavior or thoughts in the past?	____	____

Current	Past		Current	Past	
___	___	Depressed mood	___	___	Fear of dying or going crazy
___	___	Daily irritability	___	___	Excess fear of persons, places animal, objects, situations
___	___	Lack of interest/pleasure in activities	___	___	Recurrent and persistent, thoughts/behaviors
___	___	Increase in appetite			
___	___	Loss of appetite	___	___	Difficulty controlling anger/bad temper
___	___	Difficulty sleeping or poor sleep			
___	___	Decreased need for sleep	___	___	Psychological abuse
___	___	Increased need for sleep	___	___	Physical abuse
			___	___	Sexual abuse
___	___	Restlessness or inability to concentrate	___	___	Distressing memories that reoccur or intrude
			___	___	Recurrent distressing dreams
___	___	Difficulty making decisions			
___	___	Fatigue or loss of energy	___	___	Do you hear or see things that others don't
			___	___	Delusions (unreasonable thoughts or beliefs)
___	___	Feelings of worthlessness or guilt			
___	___	Feelings of hopelessness	___	___	Compulsive shopping/spending
			___	___	Excessive computer/internet usage
___	___	Recurrent thoughts of death	___	___	Not able to control impulse to steal
			___	___	Preoccupation with or frequent gambling
___	___	Racing thoughts or ideas	___	___	Compulsive sexual behavior/sexual addiction
___	___	Distractibility			
___	___	Rapid mood swings	___	___	Sense of reliving traumatic events
			___	___	Periods of time you cannot remember
___	___	Shortness of breath/dizziness	___	___	Intense reactions to certain events or anniversaries
___	___	Accelerated heart rate or chest pain	___	___	Avoidance of thought or feelings of trauma
___	___	Trembling or shaking	___	___	Avoidance of activities or situations of trauma
___	___	Sweating/feeling flushed	___	___	Detachment from feelings, people and places
___	___	Choking			
___	___	Nausea or abdominal distress	___	___	Binging/compulsive overeating
___	___	Feeling unreal	___	___	Intentional vomiting
___	___	Numbness or tingling sensation	___	___	Diuretics or laxative misuse
			___	___	Excessive dieting
			___	___	Compulsive exercise

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CHEMICAL USE HISTORY

	Never	Rarely	Sometimes	Frequently	Almost Always
-After drinking or using drugs, I have been unable to remember what happened the day before.	_____	_____	_____	_____	_____
-I experience physical discomfort that is relieved by alcohol or drug use	_____	_____	_____	_____	_____
-I am able to drink or use more drugs than I used to without feeling an increased effect.	_____	_____	_____	_____	_____

-Does anyone in your family have a problem with alcohol or drugs? Yes No

Check any substance that you use:	Frequency	Amount
Tobacco		
Caffeine		
Alcohol		
Marijuana		
Cocaine		
Other		

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member

Alcohol/Substance Abuse	yes/no	Anxiety	yes/no
Depression	yes/no	Domestic Violence	yes/no
Eating Disorders	yes/no	Obesity	yes/no
Obsessive Compulsive Behavior	yes/no	Schizophrenia	yes/no
Suicide Attempts	yes/no		

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

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4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

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