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 Signed releases can be rescinded at any time.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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