Client ID: _____________

INTAKE INVENTORY

Therapist: Ciara Musgrave, MSW, LCSW

Date: ____________

Client Information:

Full Name:______________________________

Gender: M F

Address: ____

City: ______________________________ State: _______ Zip: ____________

Primary Phone: _________________ Work Alt. Phone_________________

Email: ____

Employer/ Occupation: ____

Date Of Birth: _____________ Age: ______

Marital Status:

Married ______years. Date of Marriage: ____________ Remarried Divorced _____years

Widowed ____ Single Engaged Separated (How long?) ________

Years/ Level of Education: __________________

School/ Grade (If currently enrolled): _________________________

Religion: ____

Do you attend church at this time? ___Yes ___No ___ Occasional

Family/ Spouse/ & or Emergency Contact Information:

Spouse/Parent/Emergency Contact:

Name:____________________________________

Address: ____

City: ______________________________ State: _______ Zip: ____________

Primary Phone: ____________________ Email:__________________

Employer/ Occupation: ____

Date Of Birth: __________________ Age: ______

Marital Status:

Married ____years Remarried ____ years Divorced _____years Widowed Single Engaged

Separated (How long):____________

Years/ Level of Education: __________________

Religion: ____

Information regarding children:

Name:	Age:	Gender:	Living (In or out of home):	Grade:
______________________	_________	☐M ☐F	____________________	______
______________________	_________	☐M ☐F	____________________	______
______________________	_________	☐M ☐F	____________________	______

Client ID: ______________

Client Health:

Please identify any allergies, significant health problems, or surgeries you have had or currently have:____

____

____

Please name your current primary care physician: ____

Information regarding children:

Medication:	Dose:	Prescriber/ Physician
________________________	__________	______________________
________________________	__________	______________________
________________________	__________	______________________
________________________	__________	______________________
________________________	__________	______________________

Have you ever been seen or treated by a psychiatrist, counselor, or therapist?

Yes, Name, When? And for how long? _____________________________________

____

No Names of counselors and approximate dates of counseling ___________________

Client Counseling Data:

How did you hear about our office?

☐Website ☐Facebook/Social Media ☐Friend ☐Family Member ☐Pastor ☐Doctor

☐Other _____________________________

Chief Complaints/Areas of Concern:

Please state in a few sentences your chief needs, problems, or concerns you want to address in therapy.____

____

____

____

____

____

Symptom Checklist (Check All Current/ Recent Symptoms):

___ Anxiety/Worry	__Fear	__ Flashback/nightmares
___ Grief	__Anger management issues	__Irritability
___Checking things repeatedly	__Difficulty focusing	__Cleaning myself repeatedly
___ Depression	__Difficulty leaving home	__Loneliness
___Intense emotions	__Mood changes	__Self-Esteem issues
__Substance Abuse	__Trauma	__Conflicts at Work
__Relationship/Marriage issues	__Sexual Problems	__Guilt
___Hopelessness	__Suicidal Feelings	__Stress
___ Loss of Meaning of Life	__Disorganization	__Numb

Changes or concerns involving the following? (Please check those which apply)

___ Finances
___ Legal Matters
___ Work/Job
___ Education/School
___ Moving
___ Marital Status
___ Parenting
___ Concentration
___ Memory
___ Energy
___ Health/ Illness
___ Surgery/Injury
___ Grief/Loss
___ Addition of a Family Member
___ Family Member Leaving Home
___ Sexual Activity
___ Sleep Habits
___ Eating Habits
___ Difficulty trusting others
___ Friends
___ Alcohol Use
___ Drug Use

Additional Client Rights:

I understand that my information may not be protected from redisclosure by the requester of the information; however if the information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not redisclose such information without my further written authorization unless otherwise provided by state or federal law.

I understand that my information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R Pts. 160 & 164 and cannot be disclosed unless provided for under the act. Also, alcohol and drug treatment records are protected under the feral regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Additionally, I understand that if my record contains information relating to HIV, AIDS, communicable disease(s) alcohol abuse, drug abuse, psychological/psychiatric conditions this disclosure will include that information. HIV/AIDS information is disclosed in accordance with Communicable Disease Laws (GS130A-143).

I also understand that that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits; however if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information, service may be denied if authorization is not given.

Signature ____ Date _______________

Parental Consent if Client Is Under 18:

***Must be completed for ALL clients under age 18.

I, as legal guardian, give my authorization for Ciara Musgrave, MSW, LCSW, to counsel with the above-mentioned minor.

Signature ____ Date _______________

Client/ Client Guardian Endorsed Symptom Checklist:

__Difficulty learning/IEP

Client ID: _______________

__Complaints from school
__Problems interacting w/ other kids
__Everything must be just so
__Anxiety
__Trauma
__Careless mistakes often
__Difficulty focusing
__Problems w/ organization

__Losing things often
__Forgetful
__Fidgety & hyperactive
__Difficulty being quiet
__Difficulty waiting turns,
__Interrupting others often
__Sadness/depression
__Cutting/self-injurious behaviors
__Mood changes often
__Difficulty w/ sleep

__Problems eating/purging
__Property destruction
__Running away
__Fighting/ threatening
__Angry/argumentative,
__Stealing
__Defiant to adult/authority,
__Annoys others,
__Separation anxiety from parents/home,
__Being bullied

Payment Information:

***Party responsible for payment if other than client:

Party Responsible for Payment if Other than Client:

Name: ______________________________________ Address: _________________________________
Phone: _____________________________________
EAP Information: ____
Are you filing insurance claims? ☐Yes ☐No

Mental Health Benefits Insurance Information:

*** If you are requesting that I file the claims for you please complete the information below. **Please be advised that you are still financially responsible for the sessions whether your insurance company covers services rendered or not.**

Policyholder's Information:

Name: _______________________________________ Address: _________________________________
Policyholder's Date of Birth: __________________ Phone: ___________________________________
Employer: ___________________________________

Insurance Company Information:

Name of Insurance Company: _____________________________ Phone: ________________
Subscriber #: ____________________ Group #: ___________________________
Group Name: __________________________
Is Ciara Musgrave in or out of network? ☐In☐Out
Pre-Certification Needed? ☐Yes ☐No Number of visits per year: ____________________
Amount Paid by Insurance: _______________ Co-Pay/Co-Insurance Information: _______________
Deductible Amount: ________________ Deductible Met: ______________________
When does deductible start over? ____________________
What plan covers: ☐Individual ☐Marital ☐Family ☐Group

I, ___________________________, understand and agree to pay costs incurred, including my co-payment or those expenses not covered by my insurance, as agreed upon with the therapist during the initial session. I understand I am responsible for sessions not cancelled 24 hours in advance. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment, when necessary. Re: CONFIDENTIALITY: I understand that my sessions are confidential unless I sign a release, except for the above authorization to the insurance company. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply. My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Signature: _____________________________________ Date: _________________________

Please print name: ______________________________

Statement of Understanding:

Informed Consent:

I acknowledge I was provided ALL of the following documents: Therapy Intake Form, Therapist Disclosure Statement, and Privacy Practices

I, (Client)____, have received and agree to Therapy Intake Form, Therapist Disclosure Statement, and Privacy Practice