Today's Date: _____ Client ID: _____

CLIENT INTAKE INVENTORY

Therapist: Karla Pittman, MSW, LCSWA

Client's Full Name: _____ Gender: ☐M ☐F

Physical Address: _____

City: _____ State: _____Zip Code: _____

Primary Phone: _____ Work Alt. Phone_____

Email: _____

Employer/ Occupation: _____

Date Of Birth: _____ Age: _____

Marital Status: ☐Single, ☐Married _____ years, ☐Engaged, ☐Divorced _____ years, ☐Separated _____ years, ☐Widowed _____ years

Level of Education: _____

School/ Grade (If currently enrolled): _____

Religion: _____

Do you attend church at this time? ☐Yes ☐No ☐Occasional

Client's Emergency Contact Information:

Name: _____Relationship to Client: _____
Physical Address: _____City: _____ State: _____
Zip Code: _____Primary Phone: _____ Work Alt. Phone_____
Email: _____
Employer/ Occupation: _____
Date Of Birth: _____ Age: _____
Marital Status: ☐Single, ☐Married _____ years, ☐Engaged, ☐Divorced _____ years, ☐Separated _____ years, ☐Widowed _____ years
Level of Education: _____
School/ Grade (If currently enrolled): _____
Religion: _____

Information Regarding Client's Children

Child's Name	Age	Gender	In or Out of Home	Grade

Client Health Information

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

_____

_____

Primary Care Physician: _____

Name of Medication	Dosage	Prescriber/ Physician

Have you ever been seen or treated by a Psychiatrist, Counselor, or Therapist? ☐Yes ☐No

Name of Psychiatrist/ Counselor/ Therapist	Year	How long were you seen?

Client Counseling Data

How did you hear about our office?

☐Haven Counseling Website ☐Facebook/Social Media ☐Friend ☐Family Member ☐Pastor ☐Doctor ☐Other _____

Client Chief Complaint(s) /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

Any Changes/ Concerns involving the following?

☐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 federal 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 Karla Pittman, MSW, LCSWA, to counsel with the above-mentioned minor.

Signature _____ Date _____

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: _____ Client ID: _____

Insurance Company Information:

Name of Insurance Company: _____ Phone: _____
Subscriber #: _____ Group #: _____

Group Name: _____ Is Karla Pittman 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 copayment 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: _____

Release of Information

NC General Statute 90B-7 (f) and Section .0210(d) & (e) of the North Carolina Administrative Code both mandate that a Licensed Clinical Social Worker Associate (LCSWA) must practice with clinical supervision and immediate access to emergency clinical backup during this associate licensure period. This statute is intended to protect the client and the LCSWA during the supervised practice period. The Board will not approve practice arrangements for a LCSWA unless it is fully satisfied that clients and the public will be protected through close supervision of each clinical case by a Licensed Clinical Social Worker, who holds an MSW from a CSWE accredited school of social work and who has at least 2 years of post LCSW clinical practice experience. In addition to supervision, the Board expects there to be in place a plan for 24-hour emergency consultation and backup for the LCSWA with a North Carolina licensed mental health professional. The clinical supervisor assumes responsibility along with the LCSWA for the assessment for treatment, diagnosis, treatment planning, clinical interventions, appropriate use of the treatment relationship, referrals, case documentation, reports, collateral contacts, termination of treatment, and all other such activity for each client case under the care of the LCSWA. In addition, the supervisor oversees any other professional activity, monitors and promotes increased understanding of social work ethics, encourages an appreciation for continuing education, and facilitates growth in professional identity. The Board expects to be informed by the supervisor of any problems with judgment, clinical knowledge, clinical skills, professional ethics, practice habits, or impairment of the LCSWA that may harm any client or the public.

Statement of Understanding for client of a LCSWA in Private Practice Setting:

I, (Client)_____, have agreed to allow (LCSWA Clinician) Karla Pittman, LCSWA to utilize information from our sessions, with no identifying names, to collaborate with her supervisor Tiffany Blake, LCSW, to complete her supervision hours, in order to remain in good standing with the requirements of the social work board.

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.