Restoring Wellness Clinical Services

Client Intake Questionnaire

Restoring Wellness Clinical Services
1333 Burr Ridge Parkway, Suite 200
Burr Ridge, IL 60527

Please fill in the information below and bring it with you to your first session.
Please note: Information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Martial Status:

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

Referred By (if any): _____

Emergency Contact Person:_____ Phone:_____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____
_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

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

2. What is the primary reason for seeking mental health services at this time? _____
_____
_____

3. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

4. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating problems: _____
_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

7. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

9. How many drinks containing alcohol do you consume each week?_____

10. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

12. What significant life changes or stressful events have you experienced recently? _____
_____
_____

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 (e.g. 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	_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____
_____

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

Insurance Information

Name of primary insured:_____

If there is a balance due after insurance covers part of the visit, who will be responsible for paying the remaining balance due?_____ Relationship to client:_____

Insurance Carrier:_____ Phone number:_____
Policy #:_____ Address:_____
Group ID:_____ Date of birth (of insured):_____

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No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $75 if I fail to give at least 24 hour notice prior to cancelling my appointment except in the event of an emergency.

2. I understand that I will be charged a NO-SHOW fee of the full contracted in network rate if I fail to show for my appointment. Your contracted in-network rate is: _____

3. I understand that copayment or coinsurance is due at the time of your appointment.

4. I understand that treatment services can be terminated in the event of numerous same day cancellations.

5. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

6. I understand that the therapy session will last 45-50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Patient signature (or parent signature if minor): _____

Date: _____

Clinician's signature: _____

Date: _____

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Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last First Middle Initial

Name on Card if different_____

I authorize Dr. Andrea Graves Psychological Services DBA Restoring Wellness Clinical Services and Point of Sale/Square to charge my card for professional services as follows:

Your co-pay or co-insurance fee per session that will be charged is: _____

Type of Card: _____ Exp. Date_____

Card Number _____/_____/ _____/_____ CVV Number _____
3 (or 4) digit number on back of credit card

Card Holder's Billing Address for Monthly Card Statements

_____
Street City State Zip

Card Holder's Signature:_____Date: _____/_____/_____

Charges will appear on your credit card statement as **"SQ Dr. Andrea Graves PSY"**

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records are stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

_____ _____

Individual or Legal Representative (please print) Date

_____ _____

Signature of Individual or Legal Representative Date

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize your provider _____ to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____
Signature of Client: Date:

_____
Signature of Clinician: Date: