Client Name________________________________

Arrow Counseling Services, LLC

ADULT AND ADOLESCENT (13 YRS OLD AND OLDER) INTAKE ASSESSMENT

Please complete this form before your first appointment. *All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible.*

Name: ____

Address: ____ Date of Birth _____________________

____ Gender: Male Female (Circle One)

SS#: ____ Age:____________

How would you like us to contact you? (Please circle response)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		

Name of person completing form: ______________________________________

Relationship to person receiving services: _________________________________

In case of an emergency during a therapy session if I become unable to communicate or need non medical assistance, the person I authorize you to contact is located on the Intake Form.

Name: ____

Contact Phone: _______________________________

Special Needs

1. Do you have a need for Assistive Technology (interpreter, verbal instructions, etc.) in the Provision of Services? Yes No
   If yes, Describe:____
   ____

2. Do you have any other disabilities, disorders or concerns in the area of Special Needs ? Yes No
   If yes, Describe:__ ____
   ____

Current Presenting Issue/Concern

1. Presenting Problem/ Chief Complaint (include impact on social, work, and/or academic functioning):

____

____

____

Client Name_________________________________

2. Please check any of the following problems that you currently are or recently have experienced:

☐ Stress	☐ Marital Problems	☐ Compulsive Behaviors	☐ Anxiety
☐ Other relational problems	☐ Hallucinations	☐ Panic Attacks	☐ Physical Abuse
☐ Sexual Abuse	☐ Depression	☐ Emotional Abuse	☐ Racing thoughts
☐ Alcohol Use	☐ Verbal Abuse	☐ Eating problems	☐ Sexual Problems
☐ Work stress	☐ Drug use	☐ Gender Identity Issues	☐ Pregnancy
☐ Chronic pain	☐ Trouble sleeping	☐ Abortion	☐ Career choices
☐ Financial problems	☐ Anger	☐ Recent death	☐ Controlling
☐ Obsessive thoughts	☐ Legal matters	☐ Fears	☐ Spiritual problems
☐ Parenting problems	☐ Grief	☐ Controlled by others	☐ Other: _________________

3. Please indicate the severity of the symptoms you are experiencing:

Symptoms Experienced in the last **two (2) weeks**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	If longer than 2 weeks please indicate the # of weeks, months, years
Aggression toward others						_______ W, M, Y
Anger Outbursts						_______ W, M, Y
Anxiety						_______ W, M, Y
Attention-Deficit						_______ W, M, Y
Avoidant behaviors						_______ W, M, Y
Can't be alone						_______ W, M, Y
Binging						_______ W, M, Y
Compulsive Behaviors						_______ W, M, Y
Crying						_______ W, M, Y
Disruptive Behavior						_______ W, M, Y
Drug or Alcohol Use						_______ W, M, Y
Enuresis/ Encopresis						_______ W, M, Y
Fear of crowds						_______ W, M, Y
Fear of leaving home						_______ W, M, Y
Feeling Empty						_______ W, M, Y
Feeling worthless						_______ W, M, Y
Financial Problems						_______ W, M, Y
Fire setting						_______ W, M, Y
Flashbacks						_______ W, M, Y
Gambling						_______ W, M, Y
Grandiose Thoughts of self						_______ W, M, Y
Hallucinations						_______ W, M, Y
Headaches						_______ W, M, Y
Hearing Voices						_______ W, M, Y
Hoarding						_______ W, M, Y
Homicidal Ideation						_______ W, M, Y
Hurts animals						_______ W, M, Y
Hyperactivity						_______ W, M, Y
Impulse Control						_______ W, M, Y

Client Name___________________________________

Indecisiveness						_______ W, M, Y
Infidelity						_______ W, M, Y
Irritable						_______ W, M, Y
Isolated						_______ W, M, Y
Lack of eating						_______ W, M, Y
Lack of pleasure in doing things						_______ W, M, Y
Lack of Trust						_______ W, M, Y
Legal Issues						_______ W, M, Y
Lonely						_______ W, M, Y
Lying						_______ W, M, Y
Manipulative						_______ W, M, Y
Memory loss						_______ W, M, Y
Mood swings						_______ W, M, Y
Nightmares						_______ W, M, Y
Obsessive Thoughts						_______ W, M, Y
Oppositional Defiant						_______ W, M, Y
Out of body experiences						_______ W, M, Y
Overeating						_______ W, M, Y
Panic Attacks						_______ W, M, Y
Physical fights						_______ W, M, Y
Physical pain						_______ W, M, Y
Poor concentration						_______ W, M, Y
Poor Self Esteem						_______ W, M, Y
Poor sleep						_______ W, M, Y
Pornography						_______ W, M, Y
Post Partum Depression						_______ W, M, Y
Purging Food						_______ W, M, Y
Racing Heart						_______ W, M, Y
Relationship Issues						_______ W, M, Y
Restricting Food						_______ W, M, Y
Risk Taking						_______ W, M, Y
Sad						_______ W, M, Y
Self-Harm Behaviors						_______ W, M, Y
Sexual Dysfunction						_______ W, M, Y
Sexual Identity Confusion						_______ W, M, Y
Sexually Promiscuous						_______ W, M, Y
Sleep Disturbance						_______ W, M, Y
Spiritual Confusion						_______ W, M, Y
Suicidal Ideation						_______ W, M, Y
Suspicious of others						_______ W, M, Y
Uncontrolled spending						_______ W, M, Y
Unwanted memories						_______ W, M, Y
Verbal fights						_______ W, M, Y
						_______ W, M, Y
						_______ W, M, Y
						_______ W, M, Y

Client Name_________________________________

4. Are your problems and/or symptoms affecting any of the following?

☐ Handling everyday tasks	Self esteem	Relationships	Hygiene
☐ Work/School	Housing	Legal matters	Finances
☐ Recreational activities	Sexual activity	Health	

5. Are you motivated or hopeful about treatment, change, and the future? Yes No

Please circle the number that best indicates how motivated you are for change

1 2 3 4 5 6 7 8 9 10

Minimally motivated Moderately motivated Extremely motivated

Current and Past Psychiatric Treatment

1. Are you currently or have you ever been in psychiatric treatment of any type?

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

2. Did you have a positive experience in your previous treatment? Yes No

3. Were you compliant with previous treatment? Yes No

4. Any **history** of thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, circle all that apply: Passive Thoughts Single Attempt Multiple Attempts
If yes, explain: ____
____

5. Do you **currently** have any thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, describe: ____
____

6. Any **history** of thoughts/plans/acts/ideation or intention of homicide? Yes No
If yes, circle all that apply: Passive Thoughts Violence Towards Another
If yes, explain: ____
____

7. Do you **currently** have any thoughts/plans/acts or intention of homicide? Yes No
If yes, describe: ____

If you answered yes to the above questions, what things happen that make you want to harm yourself or others?
____
____

8. Do you feel that you are currently (within the past 6 months) at risk for Dangerous Behaviors?
Yes No
If yes, identify any situation that increases risk for dangerous behaviors: ______________________
____
____

If yes, how do you currently cope or deal with these risks? _________________________________
____
____

If yes, describe any warning signs related to the risks of dangerous behaviors:_________________
____

MEDICAL INFORMATION

1. Do you take any medications for any reason? Yes No

2. Have you always taken your medications as prescribed in the past? Yes No

Medication: Please list all medications including prescribed, over the counter and homeopathic.

Name	Dosage	Frequency	Prescribed By	Reason for prescription

Medical Providers:

3. Please list all Health Care Providers: May we contact them to coordinate care?

	Name	**Phone number**		
Primary Care Physician			Yes	No
Psychiatrist			Yes	No
Caseworker			Yes	No
Case Manager			Yes	No
Other ________________			Yes	No

Client Name________________________________

4. Medical History: *Circle all that apply:*

Breathing Problems	Diabetes	High Blood Pressure	High Cholesterol
Heart Problems	Impaired Ability to Walk	Infectious Disease	Impaired Hearing
Thyroid	Impaired Vision	Liver Problems	MR/DD/LD
Obesity	Seizure Disorder	Ulcer	GI Problems

Other:____

5. Any concerns regarding medical history: ____
____

6. Number of pregnancies: ____ Number of Live Births: _____ Birth Control? Yes No

7. Any allergies or special precautions? Yes No Unknown
If yes, *circle all that apply*:
Seasonal Medications Food Latex Animals Other
If yes, specify: ____
____

8. Do you have any special nursing/medical needs? Yes No
If yes, *circle all that apply*:

Walking	Home Health Monitoring	Nursing Home	Dialysis
Clinic Visits/Injections	Oxygen/Portable Oxygen	Pacemaker	Other

If yes, specify: ____
____

9. Do you experience limitations due to physical health or disability? Yes No
If yes, *circle all that apply*:
Lifting Not Able to Work Strenuous Activities Other
If yes, explain: ____

10. Height ___________ Weight__________ BMI __________
If BMI is outside of Healthy Range, would you like strategies to address this issue? Yes No

SUBSTANCE USE

1. Please check all that apply:

Drugs, Alcohol, or Substances:

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								

Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

DEPENDENCE

2. Do you find yourself using more of your chosen substance? Yes No
3. Do you suffer from withdrawal when you try to quit? Yes No
4. Do you use to excess? Yes No

DOES (OR HAS) YOUR USE:

5. Interfere with your daily life? Yes No
6. Place you in hazardous situations? Yes No
7. Cause you legal problems? Yes No
8. Cause you interpersonal conflict? Yes No

OTHER ADDICTIONS

GAMBLING

9. Any history of gambling? Yes No
   If yes, Describe: ____

SEX

10. Any history of sexual acting out, pornography, sex crimes, legal charges, harmful behaviors, etc.?
    Yes No
    If yes, Describe: ____

FOOD

11. Any history of overeating, restricting, and/or purging food? Yes No
    If yes, Describe: ____

OTHER ADDICTION CONCERNS (internet, video games, social media, shopping, etc.)

12. Please describe: ____

____

____

MILITARY HISTORY

1. Have you ever served in the military? Yes No   Are you currently serving? Yes No

If yes, what branch? ____

If yes, type of discharge (*Circle*): Honorable Dishonorable General Other N/A

2. If yes, *Circle all that apply:*

Positive Military Experience | Experienced Combat Situations
No Traumatic Experiences | Experienced Traumatic Events
AWOL | Injury/ Disability from Experience

Other comments on the experience, any trauma, etc.:
____
____
____

TRAUMATIC EVENTS

1. Have you ever witnessed Domestic Violence? Yes No
If yes, please explain: ____
____

2. Any current or past experience of trauma: Yes No

If yes, *circle all that apply*:

Emotional Abuse | Neglect | Physical Abuse
Sexual Abuse | Verbal Abuse | Domestic Violence
Witnessed Domestic Violence | Witnessed Abuse | Other:_________________

If yes, describe the above or <u>any other traumatic experience</u>: ______________________________________
____
____
____
____

3. Have you received services for past trauma? Yes No N/A
If no, would you be interested in receiving services? Yes No N/A

Intimate Relationships, Social and Current Living Situation

1. Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner
Number of times married: __________
If married (or in a significant relationship) more than once, explain reasons for each divorce or separation: ____
____

2. Current problems with intimate relationships (spouse, friends, children, etc.)? Yes No
If Yes, please describe ____
____
____
____
____

Client Name___________________________________

3.Please list all persons living with you (including spouse, children- step, adopted or foster, extended family, friends, etc.)

Name	Sex	Birthdate	Relationship To You	Additional Information

4. Are there any issues with your current living situation? Yes No
If yes, please describe____
____

FAMILY

1. Please list the following people in your life:

Relationship	Name	Birthdate	Describe him/her (e.g. angry, outgoing, supportive, controlling)
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

2. Describe your childhood and adolescence (atmosphere, location, significant events).

Circle all that apply:

Parents Divorced	Parents Separated	Parents Remarried
No Involvement of Biological Parents	Parent(s) Deceased	Raised by Grandparents
Raised by Others	Good/Happy Home	Strict Home
Religious Home	Unfair Home	Abusive Home
Absent Family	Multiple Homes	Other

Explain:____
____
____

3. Are significant issues from childhood impacting current presenting problem? Yes No
If yes, *Circle all that apply:*

Client Name___________________________________

Trust Issues with Current Relationships
Difficulty with Activities of Daily Living
Difficulty with Academic/School Functioning

Intrusive Memories
Ongoing Tense Relationships with Family
Loss of Family with Residual Feelings

Explain: ____
____
____

4. How well did your parents/guardians get along with each other? ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Terrible

5. How well did you get along with your parents/guardians? ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Terrible

6. Have any **family members** had a history of Mental Illness: Yes No
If yes, please describe below:

Family Mental Health Problems	Who?	Please Describe
Hyperactivity		
Sexually Abused		
Depression		
Manic Depression		
Suicide		
Anxiety		
Panic Attacks		
Obsessive-Compulsive		
Anger/Abusive		
Schizophrenia		
Eating Disorder		
Alcohol Abuse		
Drug Abuse		
Mental Retardation		

7. Family History of Medical Problems? Yes No

Family Medical Health Problems	Who?	Please Describe
Heart Problems		
Cancer		
Diabetes		
Thyroid		

CULTURAL, GENDER, AND SPIRITUAL CONSIDERATIONS

1. Primary cultural/ethnic group?

☐ Western Culture (Anglo-Saxon)
☐ Middle Eastern Culture
☐ Eastern Culture
☐ Asian Culture
☐ Latino
☐ Native American
☐ African
☐ African American
☐ Other- ________________________

Client Name___________________________________

3. Primary Sub-culture

☐ LGBT	☐ Sport- Runners, etc.	☐ Medical Field
☐ Goth	☐ Law Enforcement	☐ Other-
☐ Bikers (Motorcycles)		

4. Any Gender and/or Sexual Orientation Issues? Yes No
   If yes, describe issues: ____
   ____

5. Primary Religious Affiliation *Circle any that apply:*

☐ Christian	☐ Buddhism	☐ Wicca
☐ Jewish	☐ Agnostic	☐ Unitarian Universalist
☐ Islam	☐ Atheist ☐ Other ____________________	☐ Shaman

6. What are your spiritual beliefs and practices? ____
   ____

7. How often are you involved in religious or spiritual practices? *Circle all that apply*
   Regular Involvement   Occasional Involvement
   Special Celebrations/Holiday Involvement   No Involvement

8. Do you have spiritual strengths? No Yes
Please describe____

____

9. Do you have spiritual problems/issues? No Yes
Please describe____

EDUCATIONAL AND DEVELOPMENTAL INFORMATION

1. Do you have any problems of an academic nature? Yes No
If yes, describe issues: ____
   ____

2. Please check the level of education you have completed:
☐ HS Graduate ☐ GED ☐ Some College ☐ AA/2 yrs college ☐ BA/BS 4 yrs
☐ Some Graduate School ☐ MA/2 yrs graduate ☐ Ph.D/4+ yrs graduate school ☐ Post-Graduate

3. Were you in special education classes? Yes No Unknown

4. Describe how you did in school. *Circle all that apply*:

Good/Decent Grades	Fair/Poor Grades	Retained
Learning Disability	No Behavior Issues	Some Behavior Issues
Frequent Behavior Issues	Suspended/Expelled	Dropped out

5. Do you have a history of any developmental delays or issues? Yes No
If yes, specify: ____
____

6. Do you have qualities that could be academic strengths? Yes No
If yes, specify: ____
____

VOCATIONAL INFORMATION

1. Current employment status. (*Circle*):

Active Military	Criminal Inmate	Disabled
Employed Full-Time	Employed Part-Time	Full-Time Student
Retired	Unemployed--Not Seeking	Unemployed--Seeking

2. How long at current job? ____________________________ Days/Weeks/Months/Years

3. Do you have problems of a vocational nature? Yes No

4. Are you satisfied with your current job? Yes No

5. Have you experienced difficulty performing work or work-like activity? Yes No
   If yes, *Circle all that apply*

On Disability	Applied for Disability	Difficulty Maintaining Jobs
No Work History	Difficulty with Social Work Interactions	Medical Problems Interfere

Describe the severity/frequency of work problems of any kind: ____________________________
____

Work History (List Current or Most Recent First):

Employer: Start/End Dates: Duties, Performance, Strengths/Problems:
____

Financial Information

1. Source of income or support received during the last 12 months: *Circle all that apply*

Wages	Disability	Illegal Activity	Loans
None	Parents	Retirement	Social Security
Spouse/Significant Other	Children	Other:___________________________	

2. Do you currently have financial problems? Yes No
If yes, *Circle all that apply:*

Currently Unemployed	Numerous Medical Problems/Bills	Cannot Afford Medications
Difficulty Paying Bills	Difficulty Paying Utilities	Possible Homelessness
Owing/Paying Child Support	Legal/Probation Fees	Other

Client Name___________________________________

If yes, explain: ____

LEGAL HISTORY

1. Have you ever been arrested? Yes No

2. Do you have any present legal involvement: Yes No
   If yes, *Circle all that apply*:

Arrested, Not Convicted	Assault	Awaiting Sentence	Awaiting Trial
Convicted, Served Time	Currently in Jail	Currently in Prison	Deferred Adjudication
Deferred Prosecution	Drug/Alcohol Offense	On Bail	On Parole
On Probation	Sex Offender	Other:______________________________	

Explain:____
____

3. Do you have any past legal involvement: Yes No
If yes, *Circle all that apply*:

Arrested, Not Convicted	Assault	Awaiting Sentence	Awaiting Trial
Convicted, Served Time	Currently in Jail	Currently in Prison	Deferred Adjudication
Deferred Prosecution	Drug/Alcohol Offense	On Bail	On Parole
On Probation	Sex Offender	Other:______________________________	

Explain:____
____

STRENGTHS/WEAKNESSES/ BARRIERS TO TREATMENT

1. Describe any leisure activities or hobbies: *Circle all that apply*

Hunting/Fishing	Spending Time with Family	Playing on the Computer	Church Activities
Reading	Cooking	Working Outside	Shopping
Exercising	Home Improvement	Water Activities	Other

   Comments:_________________________ ____
   ____
   ____

2. Who makes up your current support system? *Circle all that apply:*

Boy/Girlfriend	Spouse/Partner	Coworkers	Extended Family
Friends	Immediate Family	None	Religious Organization
Self-help Group	Social Service Group	Teachers	Other:____________________

3. How do you cope with life events and daily stress? Please check all that apply

☐ Talk to family	☐ Talk to support group	☐ Other ____________________________
☐ Talk to friends	☐ Resources on internet	☐ Other ____________________________
☐ Pray	☐ Journal	☐ Other ____________________________
☐ Talk with professional	☐ Yoga/Exercise	☐ Other ____________________________

Client Name___________________________________

4. Please list your strengths: *Circle all that apply*:

Accurate Action oriented Adventurous Ambitious Analytical Appreciative Artistic Athletic Authentic Bravery Caring Citizenship Clever Compassionate Charming Communicative Confident Considerate Courageous Creativity Critical thinking Curiosity	Dedicated Determined Disciplined Educated Empathetic Energetic Entertaining Enthusiastic Fairness Fast Flexible Focused Forceful Forgiveness Friendly Generous Good looking Gratitude Hope Humility Helping Honest	Humorous Idealistic Independent Ingenuity Industriousness Inner peace Inspiring Integrity Intelligent Kindness Knowledgeable Leadership Lively Logical Love Love of learning Mercy Modesty Motivated Observant Optimistic Open	Open minded Orderly Originality Organized Outgoing Patient People skills Perseverance Persuasive Persistent Practical Precise Problem solving Prudence Respectful Responsible Self assured Serious Self controlled Speaking Spirituality Spontaneous	Social intelligence Social skills Straightforward Strategic thinking Tactful Team oriented Thoughtful Thrifty Tolerant Trustworthy Versatile Visionary Vitality Warm Willpower Wisdom Other:____________ Other:____________ Other:____________ Other:____________

5. Are there any **barriers or challenges** to treatment and to change? Yes No

If yes, *circle all that apply*

Anger	Aggression	Childcare	Cultural Beliefs
Family Members	High Anxiety	Unstable Living Conditions	Medical Complications
Memory Impairment	Pregnancy	Past Treatment Experience	Religious Beliefs
Severe Depression	Substance Use	Medication Side Effects	Transportation
Work Schedule	Other: ______________________________		

Explain: ____
____

Client Name___________________________________

Please check which Stage of Change best describes you at this time

☐ **Stage #1: Pre-Contemplation**

The Client may be aware of the costs of his/her dysfunctional behavior, however, he/she does not see them as significant as compared to the benefits. Of course, others may view this situation differently. The Client shows characteristics of interest in change, but has no plan or intention to change. The Client could be described as unaware.

☐ **Stage#2: Contemplation**

The Client has become aware of problems associated with his/her behavior, however, he/she is ambivalent about whether or not it is worthwhile to change. The Client is exploring the potential to change; desiring change but lacking the confidence and commitment to change behavior; and having the intention to change at some unspecified time in the future. The Client can be described as aware and open to change.

☐ **Stage #3: Preparation**

The client has made a decision to change and has concluded that the negatives of their behavior outweigh the positives. This decision represents an event, not a process.

The client accepts responsibility to change his/her behavior. He/ She has evaluated and selected techniques for behavioral change. Characteristics of this stage include: developing a plan to make the needed changes; building confidence and commitment to change; and having the intention to change within one month. The Client can be described as willing to change and anticipating of the benefits of change.

☐ **Stage #4: Action**

The Client is engaging in self-directed behavioral change efforts while gaining new insights and developing new skills. The Client is consciously choosing new behavior; learning to overcome the tendencies toward unwanted behavior; and engaging in change actions for less than six months. The Client is described as enthusiastically embracing change and gaining momentum.

☐ **Stage #5: Maintenance**

The Client has mastered the ability to sustain new behavior with minimal effort. He/ She has established new behavioral patterns. The Client is remaining alert to high-risk situations; maintaining a focus on relapse

prevention; and behavioral change that has been sustained approximately six months. The Client can be described as persevering and consolidating their change efforts. He/ She is integrating change into the way they live their life.

☐ **Stage #6: Termination**

The Client has adopted a new self-image consistent with desired behavior and lifestyle. The Client does not react to triggers/temptations in any situation. The client is confidence; enjoying self-control; and appreciation of a healthier and happier life. The relapse prevention plan has evolved into the pursuit of a meaningful and healthy lifestyle. As such, relapse into the former way of life becomes almost unthinkable.

I have answered truthfully and to the best of my ability regarding all of the information contained in this Adult Intake Assessment.

Initial Goals for Treatment:

1. ____

2. ____

3. ____

Patient Signature____ Date ______________________

Therapist Signature ____ Date ______________________

Client Name________________________________

Crisis and Safety Plan for ________________________

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. ____ 2. ____

3. ____ 4. ____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): See Coping Technique Handout

1. ____ 2. ____

3. ____ 4. ____

Step 3: People whom I can ask for help and social settings that provide distraction:

1. Name____ Phone______________________________

2. Name____ Phone______________________________

3. Place ____

4. Place ______________________________________

Step 4: Professionals or agencies I can contact during a crisis:

1. Clinician Name____ Phone______________________________

2. Clinician Name____ Phone______________________________

3. Arrow Counseling After Hour Emergency phone number: (717) 758-8075

4. Crisis Intervention Services Phone number: 717-851-5320

5. Hospital Address: **York Hospital, 1001 S. George St, York Pa 17401; Memorial Hospital, 325 S. Belmont St, York, PA 17405: Hanover Hospital , 300 Highland Ave, Hanover, PA 17331**

6. Emergency Services: **Dial 911 on phone**

Step 5: Making the environment safe:

1. ____

2. ____

Step 6: Medications I can take during a crisis (Take as prescribed by medical doctor)

Name	Dosage	Frequency	Prescribed By

I will not hurt myself or anyone else, but rather will abide by this plan and seek help during a crisis.

Patient Signature____ Date ______________________

Therapist Signature ____ Date ______________________

Client Name___________________________________

Mental Status Exam (For Clinician Use Only) Patient ____

Appearance
- [ ] Well Groomed
- [ ] Disheveled
- [ ] Bizarre
- [ ] Body Odor

Mood
- [ ] Normal
- [ ] Depressed
- [ ] Anxious
- [ ] Euphoric
- [ ] Irritable

Attitude
- [ ] Cooperative
- [ ] Uncooperative
- [ ] Suspicious
- [ ] Guarded
- [ ] Belligerent/Hostile

Motor Activity
- [ ] Calm
- [ ] Hyperactive
- [ ] Agitated
- [ ] Tremor/Tics
- [ ] Lethargic

Affect
- [ ] Appropriate
- [ ] Sad
- [ ] Flat
- [ ] Anxious
- [ ] Inappropriate
- [ ] Angry
- [ ] Constricted
- [ ] Labile

Thought Content
- [ ] Normal
- [ ] Morbid
- [ ] Somatic complaints
- [ ] Aggressive
- [ ] Paranoid
- [ ] Phobias
- [ ] Obsessive
- [ ]

Hallucinations
- [ ] Auditory
- [ ] Visual
- [ ] Denies

Delusional Beliefs
- [ ] Religious
- [ ] Somatic
- [ ] Persecutory
- [ ] Grandiosity
- [ ] Being controlled
- [ ] Ideas of reference
- [ ] Denies

Bizarre Delusions
- [ ] Thought Broadcasting
- [ ] Thought Insertion
- [ ] Thought Withdrawal
- [ ] Denies

Orientation
- [ ] Person
- [ ] Place
- [ ] Time
- [ ] Responds to name
- [ ] Knows familiar faces or places
- [ ] Knows own daily schedule

Thought Process
- [ ] Intact
- [ ] Tangential
- [ ] Circumstantial
- [ ] Loose Associations
- [ ] Flight of ideas
- [ ] concrete thinking
- [ ] Inability to abstract
- [ ] Follow 1-step directions

Speech
- [ ] Normal
- [ ] Soft
- [ ] Loud
- [ ] Pressured
- [ ] Halting
- [ ] Incoherent
- [ ] Slurred
- [ ] Nonverbal
- [ ] Limited communication skills
- [ ] Uses yes/no only
- [ ] Uses a picture board

Insight
- [ ] Good
- [ ] Fair
- [ ] Poor

Judgment
- [ ] Intact
- [ ] Impaired

Command Hallucinations
- [ ] Harm to self
- [ ] Harm to others
- [ ] Can resist commands
- [ ] Denies

____ ________________

Therapist Signature Date

Client Name__________________________________

Arrow Counseling Services, LLC
POLICIES & PROCEDURES

Welcome and thank you for choosing Arrow Counseling Services. Our desire is to provide professional counseling services to children, families, adolescents and adults. Please read the following information carefully and sign/initial where indicated. Your signature will provide us with your understanding of office policy and procedures as well as your consent for treatment.

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION

Information provided during therapy sessions is held in the strictest of confidence. Case notes will not be provided to a third party without written authorization from you. However, there are limits to confidentiality. These limits include:

*** Duty to Warn & Protect** - When a client discloses intentions or a plan to harm another person, the mental health professional is required warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

*** Abuse of Children & Vulnerable Adults** - When there is suspicion of abuse or neglect of a child, elderly person or disabled person, the mental health professional is required to report this information to the appropriate social service agency and/or legal authority.

*** When a court order exists to release information**

*** Supervision and Treatment Purposes** - As Owner of Arrow Counseling Services, Carla Arrow will have access to all medical treatment records, for the sole purpose of clinical consultation and administrative audits. No information in the records will be released without prior written authorization

PARENTS & MINORS

* For parents of minors, please understand that therapy being provided is not for custody purposes or disputes. Therefore, you knowingly and freely waive your right to request the release of information to your attorney or any other officer of the court/or custody purposes. Please be aware that we are not custody experts.

* Patients under the age of 18 who are not emancipated from their parents should be aware that the law may allow parents to review their child's treatment record. Due to privacy in psychotherapy being essential to successful progress especially with teenagers, it is at times, our policy to request an agreement from parents that they provide consent to waive access to their child's records. If agreed, at scheduled appointments parents will only be provided with general information regarding the progress of the child's treatment. A summary of the child's treatment will also be provided at the conclusion of the child's treatment. Any other communication will require the child's consent, unless the therapist feels that the child is in danger or is a danger to someone else, in which you as the parent would be immediately contacted. Prior to communicating any information with parents, we will discuss the matter with the child and handle any objections as appropriate.

Client Name________________________________

PROVISION FOR CRISIS MANAGEMENT

* When crises occur that require hospitalization and stabilization of an extreme nature or of extreme distress, sessions may run longer than the normal 50-60 minutes. A provision has been established that after the first 60 minutes of crisis therapy additional sessions can be added on in 30 minute increments. This would typically be used when immediate hospitalization is required, or following a traumatic event that has destabilized the family or client. This is a provision by the insurance companies to reimburse for these unexpected crises. Billing will be processed according to each individual's insurance carrier's procedure.

* After hour emergency phone calls can be directed to our on-call emergency phone line at 717-758-8075. This phone number should only be used after normal business hours (M-F 8am-8pm) for emergencies that are not life threatening and do not require medical or crisis management. This phone number should not be used to reschedule appointments or contact your therapist to discuss matters that can be handled during the next business day.

TELEPHONE CALLS

* Occasionally the need to talk to your therapist may arise between normally scheduled sessions. Your therapist will respond to your call within 48 hours during his or her normal business hours. If you require more than a brief (e.g., 5 minute) conversation and you decide your issue or concern cannot wait until your next scheduled session, you will be billed $1.00/minute.

LENGTH OF SESSIONS

* Psychotherapy sessions are 54 minutes in length beginning at your appointed time and concluding after 54 minutes. Since your therapist has sessions scheduled after yours, the sessions must end at the appoint time regardless of when you arrive, and the full session fee will be charged. Therefore, it is to your benefit to be on time. Additionally, due to the nature of the work we do, there may be times when crisis arises and may result in the need to reschedule your appointment. We will make every effort to reschedule your appointment at a mutually agreed upon time. We ask your understanding when these rare occasions occur.

FEES

All services are billed at a per session rate. All co-payments, co-insurance payments, or private payments are due at the time of services. The current fee schedule is as follows:

* Initial Assessment Session: $200

* Individual Session (60 minutes): $150

* Couple or family session $150

* A sliding scale is available for those with financial difficulties, who do not have insurance (based on gross income and number of household members)

* No Show or late cancellation fee is $70 per session missed.

* Emergency cancellations less than 24 hours in advance will result in a $70 cancellation fee.

* Phone Calls from a client regarding clinical treatment content will be $1 a minute.

* For copies of medical records that are not able to be sent electronically via secure email fees will be: $.05 per one sided page and $1 per minute records preparation fee. The therapist will inform the client of the amount due for copies of medical records and payment will need to be received before copies of records are released.

* Any forms such as Disability, FMLA, etc., that are not filled out during the client's session will be charged at $1 a minute. The therapist will inform the client of how long it took to fill out the forms and payment will need to be received before forms are released.

* Court appearances are billed at $150 per hour that the therapist is required to be present.

* If the court hearing is outside of the York County Court area, the therapist's time to travel to the court hearing will be paid at $30 per hour. Any mileage over the amount that it would take the therapist to get from their home to Arrow Counseling Services will be paid at $.56 a mile.

* Any letters outside of coordination of care will be billed at $1 minute.

***NOTE:** When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Please note that most insurance carriers do not reimburse fees for cancellations or missed appointments. Therefore, it will be the client’s financial responsibility to make late cancel or no show fee payments.

SCHEDULING POLICY

In most cases, issues are not resolved in one therapy session. At the time of the initial appointment the therapist will usually establish the next appointment within one week. Appointment frequency is based on the therapist’s assessment of what will be most effective and productive for you. During the initial phase of therapy, ongoing appointments are generally scheduled weekly or bi-weekly. Please note:

*If you cancel two appointments within a 6 month period, we will only be able to schedule one appointment at a time.

*If you late cancel or no show 2 or more times within a 6 month period, you will not be able to schedule in advance and you may be discharged from services. You will be placed on a cancellation list and will be called when your therapist has openings in his or her schedule.

If you cancel any appointment with less than 24 hours notice, the cancellation fee always applies.

BILLING & FINANIAL RESPONSIBILITY

* For health insurance holders, Arrow Counseling Services participates with a number of insurance providers. Please contact your insurance carrier prior to your first appointment to verify the following information:

* Is my Arrow Counseling Services therapist a participating in network provider?

* Does my insurance policy provide mental health benefits?

* Do I have a co-pay or co-insurance?

* Do I have a deductible that needs to be met?

* Do I need pre-authorization for services?

Please be able to provide this information prior to your first appointment. If your insurance requires a preauthorization, please bring the authorization number to your first appointment.

INSURANCE BILLING

* We will bill your provided healthcare insurance company and follow the contractual obligations that exist between your healthcare insurance company and our agency. Our office will only file an insurance claim if our office is a participating provider. Otherwise, it will be your responsibility to seek reimbursement from your insurance company, and you will be responsible for payment in full to Arrow Counseling Services. You have a responsibility to be aware and understand the provisions of your healthcare insurance policy. Please remember that insurance and behavioral health plans are a method of reimbursement for services, and not a substitute or guarantee of payment. Please understand that insurance is a contract between you and your insurance carrier. Therefore, in the event that your insurance company does not reimburse for services rendered as anticipated, you will be responsible for all incurred fees and expenses and will be billed accordingly.

* For seIf-pay clients, or those with non-participating or out-of-network plans, full payment is expected at the time of service. Our office will be glad to provide you with an invoice to potentially obtain reimbursement.

* Payment for services may be made by cash, check, credit card or HSA account cards. Please make all checks payable to Arrow Counseling Services, and provide payment to the office manager before your session starts. If the office manager is not on site, please have your check written ahead of time so that your full session time can be designated for therapy. Please make every attempt to have exact amount for cash payments. Change may not be able to be provided. Returned checks will result in a charge of $35.00 to cover bank charges and processing fees.

***NOTE:** Again, all payments are expected at the time of service. If you do not have your payment on the date of service, we reserve the right to reschedule your appointment.

EMERGENCY TREATMENT

* In the event of a psychiatric emergency, do not phone your therapist or Arrow Counseling Services office. Instead, call 911 or go immediately to your local emergency room. Then you should call your therapist. If your therapist is unable to be reached, please leave a message and your therapist will contact you as quickly as possible.

*In case of an emergency during a therapy session, if you become unable to communicate or need medical assistance, the person you have indicated as your emergency contact on your Intake Form will be contacted, and by signing this form, you authorize me to do so.

TERMINATION

* In the event you choose to terminate counseling with ACS it is our policy to consider anyone terminated if, the therapist or the office has not had any contact with you by phone, email or written correspondence and you have not continued with the therapy process for 30 calendar days after your last scheduled appointment. If after the 30 days you would like to schedule a follow up appointment, please call the office.

*If we do not hear from you by the end of the 60 day period as prescribed, we will assume that you are not interested in pursuing counseling at this time and we will close your file.

*If after file closure, your circumstances change and you wish to pursue counseling, we would welcome the opportunity to work with you. However, once your file is closed, you will have to go through the intake process again in order to schedule an appointment.

Community Resource Guide and Re-engagement with Services if needed

* The Community Resource Guide is a handout that each client receives which helps give them other options for support within the community. You are able to access these resources and opportunities at any time during and after treatment. Specific instructions are also given on how to reengage in services at Arrow Counseling Services LLC if needed. By signing this form, you are signifying that you were given a Community Resource Guide with instructions on how to reengage in services if needed.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HAW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

l. My Duties

* The privacy and confidentiality of your health information is very important and I am committed to protecting it to the extent that I can, consistent with law and ethical standards. Your health information includes records that I create and obtain in order to provide care to you. For example, it includes a record of your symptoms, examination and test results if applicable, diagnoses, summary of treatment and referrals. Bills, insurance claims and other payment information is also included in the record of your health information.

* This Notice tells you about the different ways I may use and disclose your health information. lt also describes your rights and my obligations. I am required to: maintain the privacy of your protected health information as required by law; provide you with this Notice of my legal duties and privacy practices with respect to your health information that I collect and maintain; and follow the terms of my Notice that is currently in effect.

ll. Uses and Disclosures of Protected Health Information - Payment, Treatment and Health Care Operations

* Under federal law, I am permitted to use and disclose personal health information without authorization for treatment, payment and health care operations. However, state law or the ACA’s Code of Ethics may require me to obtain your express authorization before disclosing certain portions of your record and protected health information. I may also choose to require your release of information in certain circumstances. Treatment: For example, I may discuss certain aspects of your counseling with your psychiatrist in order to provide the best treatment and medication for you. Likewise, your psychiatrist may discuss certain medication management issues with me so I can collaborate in treatment. Payment: If your health insurance company needs more information for payment than what is printed on your receipt, I will provide only the minimum amount of information necessary for the insurance company to process the claim. This may include the diagnosis and explanation of care provided.

III. Other Uses and Disclosures of Protected Health Information

Besides use and disclosure for treatment, payment and health care operations, I may use and disclose your personal health information without authorization for the following purposes:

* **Abuse, Neglect or Domestic Violence**: I may disclose protected health information about you to a state or federal agency if I am required or permitted by law to report child or vulnerable adult abuse or neglect or domestic violence. When possible, and as consistent with my professional judgment in order to avoid harm to you or others, I will inform you of the need to make such a disclosure.

* **Judicial or Administrative Proceedings:** I may disclose health information about you in the course of a judicial or, administrative proceeding as required by law. For example, if a court orders me to release information, I must generally comply with the order. In some circumstances, I may be required to turn over information in response to a subpoena. If I receive a subpoena for your records, I will attempt to contact you and/or your attorney if that is feasible. Your attorney may be able to file a motion which will lead to a court order.

* **Law Enforcement:** If authorized or required by law, I may release health information to law enforcement officials. For example, I may release information to help identify a suspect or fugitive or report a crime related to a medical emergency.

* **Health Oversight Activities:** I may disclose health information about you to governmental, licensing, auditing or health care accrediting agencies where authorized or required by law. For example, information may be released to the state licensure board if a complaint is filed against me.

* **Appointment Reminders and other Health Services:** I may contact you to remind you of appointments or to inform you of treatment alternatives or other options and services that may be of interest to you.

* **Prevention of Serious Threat to Public Health or Safety:** In accordance with law and ethics, I may use and disclose health information about you to prevent or minimize the risk of a serious and imminent threat to your health and safety or to the health and safety of another person or the public.

* **Minors:** If you are an unemancipated minor under the law of the state of Pennsylvania, I may, in certain circumstances, disclose health information about you to a parent, guardian or other authorized person, in accordance with law and ethics.

*** Parents:** If you are the parent of an unemancipated minor, I may disclose health information about your child to you in certain circumstances. For example, if I must legally obtain your consent in order to treat your child, when you are acting as your child's "personal representative" under law, I may disclose health information about your child to you. In other circumstances, such as when your child is legally authorized to consent to treatment without a separate consent from you, and where the child does not request that you act as his/her "personal representative", I may not disclose health/mental health information about your child to you without your child's authorization.

*** Personal Representative:** If you are an adult or emancipated minor, I may disclose health information about you to a "personal representative" authorized to act on your behalf in making health care decisions.

* **Research and Related Activities:** I may disclose health information about you for research purposes in accordance with my legal and ethical obligations. Additionally, federal law allows us to create a "limited data set" which does not include information such as your name, address, Social Security number. This limited data set may be shared with those who have signed a contract promising to protect the privacy of the information and to use it only for research, health care oversight and health care operations.

* **Worker's Compensation/ Employee Assistance Program:** I may disclose health information about you for worker's compensation or employee assistance program as authorized or required by law. These programs provide benefits for certain work-related illnesses and injuries or employee related mental health issues.

* **Required by Law:** I may disclose information about you when required to do so by federal, state or other applicable law.

* **Authorization Required for Other Uses or Disclosures:** I will obtain your written authorization for any other use or disclosure of your protected health information. You have the right to revoke any authorization, in writing and in accordance with this Notice, to the extent that action has not been taken in reliance on the authorization. Psychotherapy notes are not among the records that you may, by law, review or copy unless I believe it is in your best interests to access them. I will be happy to discuss the issue of psychotherapy notes with you if you have any questions.

IV. Your Rights Regarding Health Information

You have certain rights regarding health information that I create and maintain about you. These rights include:

* **Right to Inspect and Copy**. With certain exceptions (such as psychotherapy notes as described above, information collected for certain legal proceedings and health information restricted by law), you have the right to inspect and/or receive a copy of your records. If I am unable to accommodate your request, I will inform you in writing of the reason for the denial and your right if any, to request a review of the denial. I may charge you a reasonable fee for copying your records.

* **Right to Request Communication by Alternative Means**. If you would like me to communicate with you in a certain way (e.g., by leaving a message on your office phone number) or at a certain location (e.g., home only), I will make efforts to accommodate such requests for confidential communications as long as they are reasonable. I may request that you give me an alternative means to reach you if there is an emergency. If I am unable to contact you using your requested means, I may contact you using any information I have.

* **Right to Request Restrictions.** You have the right to request that I restrict or limit certain uses and disclosures of information. You may be asked to submit this request in writing. However, I am not required to agree to your request. I will let you know whether I am able to honor your request.

***Right to Receive a Paper Copy of this Notice**. You have the right to request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

In order to make any requests or exercise any rights set forth above, you must submit your request in writing to:

Carla V. Arrow, MS LPC NCC

Client Name________________________________

1427 East Market Street
York, PA 174O3

You may also contact Carla Arrow by phone or e-mail during normal office hours.
717-755-O011 (ph) or Carrow@ArrowCounselingServices.com (email)

V. Questions or Complaints

* If you believe that your privacy rights have been violated, you may file a written complaint and address it to Carla V. Arrow (listed in section IV above). If that does not satisfy your concern, you may complain to the Secretary of Health and Human Services (HHS). Instructions for filing a complaint with the appropriate office for your region can be found at http://www.hhs.gov/ocr/howtofileprivary.pdf. Alternatively, you may call 1-800-368-1019 and request instructions for filing a complaint. There will be no retaliation for filing a complaint.

VI. Future Changes to this Notice and My Privacy Practices

* I reserve the right to amend the terms of my privacy practices and policies and this Notice. If this Notice is revised, the changed terms will apply to all health information about you, including information obtained before the effective date of the revised Notice. Any materially revised Notice will be distributed to all clients, posted in my waiting area and posted on my website.

CLIENT RIGHTS AND RESPONSIBILITTES

As a client of Arrow Counseling Services, you have the following rights:

* To be treated with dignity and respect at all times. You will not be subjected to harsh or unusual treatment or be deprived of any civil rights while a client at Arrow Counseling Services;

* To expect that a licensee has met the minimal qualifications of training and experience required by state law;

* To examine public records maintained by the Board and to have the Board confirm credentials of a license.

* To obtain a copy of the Code of Ethics;

* To report complaints to the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors;

* To be informed of the cost of professional services before receiving the services;

* To be assured of privacy and confidentiality while receiving services as defined by rule and law, excluding the following exceptions:

* A Reporting suspected child abuse;

* Reporting imminent danger to client or others;

* Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;

* Providing information concerning licensee case consultation or supervision; and

* Defending claims brought by client against licensee;

Client Name________________________________

* To be free from being the object of discrimination on the basis of race, religion, gender; or other unlawful category while receiving services.

As a client of Arrow Counseling Services, you have the following responsibilities:

* To provide accurate and complete information concerning your present complaints, present/past medical/personal history and other matters relating to your current condition and life circumstances.

* To make it known to the therapist whether he/she comprehends clearly the course of treatment and what is expected from him/her.

* To read all handouts: Policies & Procedures, Client Notice of Privacy Practices, Client Rights and Responsibilities, and Client Release of Information Forms.

* To keep appointments and notifying the therapist at least 24 hours in advance if you are unable to make your appointment.

* To adhere to treatment recommendations. While entering into therapy is voluntary during the course of your care, your therapist will make recommendations that are specific to your presenting problem and circumstance. While there are benefits to following these recommendations, choosing not to adhere to them could result in consequences. Those consequences will be discussed in greater detail during the session.

* To pay all fees incurred for treatment services at the time of service.

Our desire is that your experience with Arrow Counseling Services will be helpful and productive for you. If you have any questions regarding these policies and procedures or other aspects of your relationship with us, please discuss them with your therapist or call the office at 717-755-0011.

As a client of Arrow Counseling Services, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Arrow Counseling Services. I also acknowledge that I have read and have been given a copy of all Policies and Procedures including my consent for treatment by Arrow Counseling Services.

Client Signature: ____ Date: _________________

Client Signature: ____ Date: _________________

This Notice is effective 11/1/2007 and updated 01/01/2018.