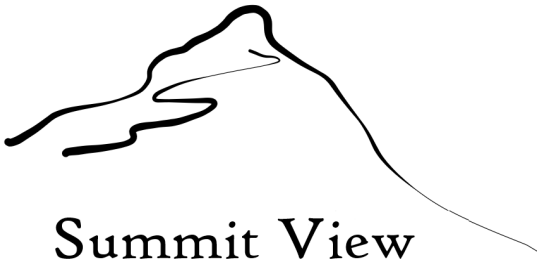


Summit View Counseling

1431 S 550 E, Orem UT 84097 801.318.4721

Intake Information

Client Name: _____ Social Security #:_____
Marital Status: _____ Sex: _____ Date of Birth: _____
Age: _____ Race: _____ Driver's License #:_____
Address:_____
Street City State Zip
Home Phone:_____ Cell: _____ Work: _____
Email Address: _____
Spouse Name:_____
Spouse Address:_____ Phone: _____
Emergency Contact:_____Phone:_____
Place of Employment: _____ For how long? _____

Presenting Problem [Why have you come to counseling?]: _____
_____
_____

Referral Source:_____
Race/ Ethnicity: _Caucasian _African American _Asian _Hispanic/ Latino _Native American _Pacific Islander _Other_____
Marital Status: _Never married _Partnered _Married _Separated _Divorced _Widowed _Other_____
Number of Children: _____
Ages and Names of Children: _____
_____

<u>Current Concern</u>

What are your current symptoms?
_____
_____
How long have you felt these symptoms?
_____
_____

Personal Psychiatric History

Are you currently receiving psychiatric services, professional counseling, or psychotherapy somewhere else? _Yes _No

Explain your previous experiences with psychotherapy: _ N/A

_____

_____

Name of current and /or previous therapist: _N/A

_____

Have you had previous care for the treatment of substance use/ misuse/ abuse (inpatient/ outpatient)? _Yes _No

Previous substance abuse facilities attended: _ N/A

_____

_____

Have you had suicidal thoughts recently? _Frequently _Sometimes _Rarely _Never

Have you had them in the past? _Frequently _Sometimes _Rarely _Never

Have you ever experienced any of the following?

Extreme Depressed Mood: _Yes _No
Wild Mood Swings: _Yes _No
Rapid Speech: _Yes _No
Extreme Anxiety: _Yes _No
Panic Attacks: _Yes _No
Phobias: _Yes _No
Sleep Disturbance: _Yes _No
Hallucinations: _Yes _No
Unexplained losses of time: _Yes _No
Unexplained memory lapses: _Yes _No
Alcohol/ Substance Abuse/ Misuse: _Yes _No
Frequent Body Complaints: _Yes _No
Eating Disorder: _Yes _No
Body Image Problems: _Yes _No
Repetitive thoughts (e.g., obsessions) _Yes _No
Repetitive Behaviors: _Yes _No
Homicidal Thoughts: _Yes _No
Suicide Attempt: _Yes _No

Trauma History

Have you ever experienced any past traumatic events?

_____

_____

When did they occur?

_____

_____

Family Psychological Health

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (CHeck all that apply and list family member, e.g., sibling, parent, uncle, etc.):

Depression: _No _Yes _____
Bipolar Disorder: _No _Yes _____
Anxiety Disorders: _No _Yes _____
Panic Attacks: _No _Yes _____
Schizophrenia: _No _Yes _____
Substance Abuse: _No _Yes _____
Eating Disorders: _No _Yes _____
Learning Disabilities: _No _Yes _____
Trauma History: _No _Yes _____
Suicide attempts: _No _Yes _____

Health/ Medical

Do you have allergies? _Yes _No
If you have allergies, to what substance(s)?

_____

_____

Do you smoke/ Vape? If yes how many/ much a day? _____
Do you or your partner use drugs? If yes how much, often?

_____

_____

How is your physical health at present? (please circle)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very Good**

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

Do you have a primary care doctor you usually see for medical services? If so write their name and phone number below:

_____

When was the last time you had a general medical checkup?

_____

Are you pregnant? _Yes _No
If pregnant, how many months along is your pregnancy? _____

Are you currently being treated for any health problems or recovering from an injury, surgery, etc.? If so briefly describe here:

_____

_____

Are you having trouble with your sleep habits? _No _Yes
If you are having trouble with sleep check where applicable:

_ Sleeping too little _Sleeping too much _Poor quality sleep _Disturbing dreams _Other_____

How many times a week do you exercise? _____
Approximately how long each time? _____

Are you having difficulty with appetite or eating habits? _Yes _No
If yes check which of the following are applicable:
_Eating less _Eating more _Binging _Restricting _Other _____
Have you experienced significant weight change in the last 2 months? _Yes _No

Do you use alcohol regularly? _Yes _No
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?
_Daily _Weekly _Monthly _Rarely _Never

Current Medications

Are you currently taking prescribed psychiatric medications (antidepressants or others)? _Yes _No
If yes please list all prescription medications you currently take and for what reason.

Current Medications	For what condition?	Dosage (How much?)	Frequency (how often?)	Started taking when?	Comments/ Problems/ Concerns

Past medications/ For what conditions? (List sedatives, pain medications, sleeping pills, antidepressants. etc.):

_____
_____

Substance Use History

Drug Type Used	Age of First Use	Date Last Used	Typical Amt. Used	Most Used in 1 Day
Alcohol				
Marijuana				
Cocaine				
Heroin				
Hallucinogens				
Amphetamines/ Methamphetamine				
Inhalants OTC Medications				
Rx Medications				
Entacogens				
Other				

What is your substance of choice (does not have to be related to addiction issues)?

_____

Why do you use substances (does not have to be related to addiction issues)?

_____

Longest period of sobriety (does not have to be related to addiction issues)?

_____

Is anyone concerned about your substance use?

_____

Do you feel you have any addiction issues aside from drugs or alcohol (gambling, pornography, co,mpulsive spending, food, etc.)?

_____

Social Relationships

Are you currently in a romantic relationship? _Yes _No
If yes how long have you been in the relationship?_____
How would you rate the quality of your current relationship?

_____

How many marriages have you had and how old were you when you were married/ divorced?

_____

Who lives in your home with you?

_____

In the last year have you experienced any significant life changes or stressors, please list:

_____

_____

Estimate how many hours per day you spend online (Facebook, YouTube, inmternet gaming, texting, browsing, etc.):

Facebook:___ YouTube:___ Gaming:___ Texting:___ Browsing:___ Work/ School:___ Other:___

Do you feel technology use is balanced and healthy or could it use improvement? Please explain:

_____

_____

Education/ Career

What is the highest level of education you have attained?

_High School _Associate _Bachelor _Master _Doctorate _Vocational _Other

What are your educational goals?

_____

_____

What are your career goals?

_____

_____

Employment

Are you currently employed? _Yes _No

If yes who is your current employer/ what is your position?

_____

If yes, what are the positives of your current position?

_____

Please list any negatives or work-related stressors at your current position, if any:

_____

_____

Religion

Do you consider yourself to be religious? _Yes _No

If yes what is your faith?

_____

If no, do you consider yourself to be spiritual? _Yes _No

What role does religion/ Spirituality play in your life?

_____

Legal History

Have you ever been arrested? _Yes _No

Have you ever been charged and/ or pled guilty to any misdemeanors or felonies? _Yes _No

If yes, what were the charges?

_____

Other

What do you consider to be your strengths?

_____

_____

What do you consider to be your limitations?

_____

_____

What do you like most about yourself?

_____

_____

What are some effective coping strategies that you have learned and use?

_____

_____

What are your goals for therapy?

_____

_____

What are your expectations or preconceived notions of the therapeutic process?

_____

_____

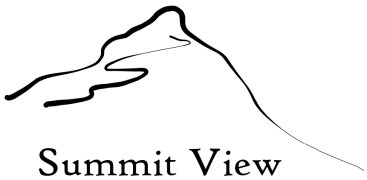
By signing below, I understand and agree to the terms and conditions outlined in this and in the following documents, including: Informed Consent/Client Rights and Consumer Agreement/Payment Policy, and I consent to mental health treatment at Summit View Counseling.

_____

Client Signature **Date**

_____

Parent/Guardian/Responsible Party **Date**



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Informed Consent/Client Rights

I, _____, authorize Brody Bates, CMHC to provide mental health services. I understand that I have a right to withdraw consent at any time.

Confidentiality: All information and records will be kept confidential and will be held in accordance with state and federal(HIPAA) laws regarding the confidentiality of such records. However, records and/or information will be released regardless of consent under the following circumstances:

• *According to state and local laws, clinicians must report all cases of physical and sexual abuse or neglect of minors or the elderly to the appropriate agency;*

• *According to state and local laws, clinicians report all cases in which there exists a danger to self or others;*

• *In the event that a client is in need of emergency services and other medical personnel need to be contacted; and*

• *In the event that your records may be subpoenaed by court.*

Right to Access Records: Adult clients and legal guardians of minors have the right to access the record of the services provided for them by Brody Bates, CMHC. Records will be retained for seven years. Records whose retention has been met shall be destroyed by shredding to protect client confidentiality.

Treatment: Clients have a right to receive and understand information and instructions about their treatment, know the nature and purpose of services, receive services based on an individual treatment plan, and be part of the process of updating the treatment plan when his or her needs change.

Treatment of Minors: Treatment of children less than 18 years of age will be provided only with the consent of the legal guardian. By signing this consent form, the client acknowledges that he or she is the legal guardian of any minor presented for treatment.

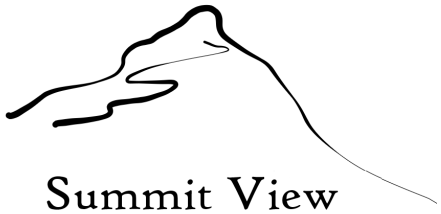
Voluntary Termination: Clients have the right to make informed choice of services, consent to or refuse services before they are provided, and refuse services with the receipt of information and the consequences of refusal.

Involuntary termination: Services may be terminated if a consumer fails to keep their scheduled appointments following excessive no shows. Services may be terminated if a determination is made that the client is unsafe to others or themselves, and their presence is disruptive and/or unsafe to others seeking or providing treatment. If services have been terminated, client may request a review of the situation and reinstatement of those services from Brody Bates, CMHC.

Freedom from Potential Harm: All clients have the right to humane care and protection from harm. Brody Bates, CMHC and Summit View staff are prohibited from any use of psychological abuse, including humiliating, threatening, and exploiting actions. All instances of abuse or neglect of an adult should be reported to Adult Protective Services at 1 (800) 371-7897. Circumstances of child abuse and neglect should be reported to Utah's Division of Family and Children's Services (801) 538-4171 or to the local Police Department.

_____

Client Signature: Date:



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Consumer Agreement/Payment Policy

Client Name: _____ Date: _____
Please read the following statements very carefully as you will be held responsible for the information listed and there will be NO EXCEPTIONS made to these policies.

1. If you cannot make a scheduled appointment, please call to cancel or reschedule 24 hours in advance. If you do not call, or call less than 24 hours in advance to cancel or reschedule, you will be billed the full session rate. This fee will be charged to your credit card on file, and must be paid prior to scheduling another appointment. _____ (Client/Responsible Party initials)
2. Clients who miss two appointments without calling to cancel, or consistently call to cancel or reschedule, may be terminated from treatment. _____ (Client/Responsible Party initials)
3. All services will be paid for at the time of the first visit. If your insurance is out of network, we will expect payment from you at the time of service. It will be your responsibility to submit any claims to your insurance company for direct reimbursement to you. Failure to pay will prevent you from scheduling another appointment until your account is paid in full. Interest shall accrue on any amounts not paid at the time of service (other than insurance and crime victim reparation payments) at a rate of 1 ½ % per month (18% per annum). In the event of nonpayment, Summit View Counseling may recover the cost of collection, including a reasonable attorney fee. All clients will be billed the standard rate for services provided. You will be responsible for any unpaid balance if your insurance company or clergy refuses payments. Please pre-authorize treatment with your insurance company if necessary and know the limitations of your coverage. _____ (Client/Responsible Party initials)
4. In case of an emergency, Summit View Counseling staff requires permission to seek medical treatment for you if you are physically or mentally incapacitated. By initialing, you agree to allow Summit View Counseling staff to act on your behalf in case of an emergency. _____ (Client/Responsible Party initials)

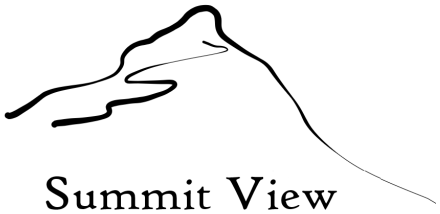
Standard Fee for Services:

Individual Session: $130/50 min
Sliding Scale Session: $____/50 min
Family/Couple Session: $150/50 min

No Show/Late Cancel Fee: Full Session Fee
Returned Check Fee: $30
Declined Credit Card Fee: $30

I acknowledge that I have read and agree to Summit View Counseling's Payment Policy

_____ Client/Responsible Party



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Payment Information

As indicated in the Payment Policy that you received, Summit View Counseling requires you to keep a credit card on file so we can collect co-insurances, deductibles, and other unpaid account balances as soon as your insurance carrier assigns the appropriate amount of patient responsibility. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.

Credit Card Type: _____
Credit Card #: _____
Three digit code: _____

Expiration date: _____
Name on card: _____
Zip code assigned to card:_____

I hereby authorize Summit View Counseling to bill my credit card for any coinsurances, deductibles, and other unpaid account balances.

_____

Client/Responsible Party Date