BRIDGE OF HOPE
counseling services

WELCOME TO BRIDGE OF HOPE COUNSELING SERVICES!

Please fill out this incoming packet as it pertains to the client being seen. Thank you!

I. INITIAL CLIENT INFORMATION

TODAY'S DATE

CLIENT'S NAME
FIRST *LAST* *MIDDLE INITIAL*

BIRTHDAY **AGE** **GENDER**

MARITAL STATUS
○ SINGLE ○ DATING ○ MARRIED ○ PARTNERSHIP ○ SEPARATED
○ DIVORCED ○ WIDOWED

ADDRESS

CITY **STATE** **ZIP**

PHONE(S)
CELL PHONE *HOME PHONE*

EMAIL

Authorization for Bridge of Hope Counseling Services, P.C. to:

Send mail to the address listed above	☐ YES	☐ NO
Leave voice messages on the phone listed above	☐ YES	☐ NO
Leave text messages on the cell phone listed above	☐ YES	☐ NO
Send email to the email address listed above	☐ YES	☐ NO

IMMEDIATE FAMILY MEMBERS:

Name	Age	Occupation/Grade	Relationship	Living in Your Home?

II. EMPLOYMENT INFORMATION

OCCUPATION/TITLE

TIME IN POSITION

PLACE OF EMPLOYMENT

ADDRESS OF EMPLOYMENT

CITY

STATE

ZIP

III. EMERGENCY CONTACTS

In case of emergency, contact:

NAME

RELATIONSHIP

ADDRESS

CITY

STATE

ZIP

PHONE

PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE

PSYCHIATRIST'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE

IV. REFERRAL SOURCE

How did you hear about us?

☐ Facebook ☐ Friend/Family Member ☐ Physician/Psychiatrist

☐ Psychology Today ☐ Website ☐ Other

If other, please explain: _____

Name of Referral Source: _____

V. INSURED/RESPONSIBLE PARTY INFORMATION

All items in this section must be completed in order to bill your insurance. If using private pay, write N/A and skip to the next page.

POLICY HOLDER NAME
FIRST *LAST* *MIDDLE INITIAL*

POLICY HOLDER'S ADDRESS

CITY **STATE** **ZIP**

POLICY HOLDER'S PHONE **DATE OF BIRTH**

RELATIONSHIP TO CLIENT

INSURANCE PROVIDER'S INFORMATION:

INSURANCE COMPANY

I.D. NUMBER **GROUP NUMBER**

MENTAL/ BEHAVIORAL HEALTH PHONE
(1-800 NUMBER ON BACK OF CARD)

VI. COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, **however we do need your physician's/ psychiatrist's name and demographic information for insurance billing.**

Check one: ☐ You may inform my **PHYSICIAN.** ☐ I decline to inform my **PHYSICIAN.**

Physician's Name: _____

Physician's Phone #: _____

Physician's Address: _____

_____ _____

Client Signature **(**Communication with **PHYSICIAN)** Date

Check one: ☐ You may inform my **PSYCHIATRIST.** ☐ I decline to inform my **PSYCHIATRIST.**

Psychiatrist's Name: _____

Psychiatrist's Phone #: _____

Psychiatrist's Address: _____

_____ _____

Client Signature **(**Communication with **PSYCHIATRIST)** Date

VII. PRESENTING PROBLEM AND TREATMENT HISTORY

Please briefly describe why you are seeking counseling:

Please list previous counseling, outpatient treatment, substance abuse treatment or hospitalization. Please include approximate dates, facilities and/or therapists:

Please describe significant medical history:

Please list all prescription and non-prescription medications and supplements. Include dosages and prescribing physician.

Do you take all your medications regularly, as prescribed? ☐ Yes ☐ No ☐ N/A

If no, please explain: _____

LIFE EVENTS/STRESSORS

Please check all significant life events/stressors that you have experienced in the past year.

- ☐ End of Relationship
- ☐ Marriage/Commitment
- ☐ Job/School Pressure
- ☐ Sexual Issues
- ☐ Family Issues
- ☐ Divorce/Separation
- ☐ Becoming a New Parent
- ☐ Major Illness
- ☐ Trauma
- ☐ Death in the Family
- ☐ Moving
- ☐ Job Change
- ☐ Legal Issues
- ☐ Finances
- ☐ Other

If other, please explain: _____

PSYCHIATRIC QUESTIONS

Have you ever attempted to end your life?	☐ Yes	☐ No
Do you currently have a plan to harm or kill yourself?	☐ Yes	☐ No
Do you have a history of self-harming?	☐ Yes	☐ No
Do you have a family history of suicide?	☐ Yes	☐ No
Do you ever think about hurting or killing other people?	☐ Yes	☐ No
Do you have a plan to harm somebody else?	☐ Yes	☐ No
Do you have a history of being violent or assaultive?	☐ Yes	☐ No
Have you ever been diagnosed with a psychiatric disorder?	☐ Yes	☐ No
Have/Do any of your immediate family experience(d) mental health issues?	☐ Yes	☐ No

If you answered yes to any of the questions above, please use this space below to explain.

SYMPTOMS

Please check any symptoms you are CURRENTLY experiencing:

- ☐ Change in Appetite (More/Less)
- ☐ Feeling Sad / Crying Spells
- ☐ Too Little Sleep (Falling/Staying Asleep)
- ☐ Sleeping More Than Usual
- ☐ Fatigue / Loss of Interest or Pleasure
- ☐ Avoiding Friends or Family
- ☐ Expect Failure
- ☐ Decreased Concentration
- ☐ Thoughts of Death
- ☐ Cutting / Burning Oneself
- ☐ Suicide Plan or Attempt
- ☐ Depression
- ☐ Often Sick
- ☐ Loneliness
- ☐ Slow Moving
- ☐ Hopelessness
- ☐ Confusion
- ☐ Worthlessness
- ☐ Lack of Confidence/Low Self-Esteem
- ☐ Guilt
- ☐ Reckless or Dangerous Behavior
- ☐ Racing Thoughts
- ☐ Inflated Self-Esteem
- ☐ Marital/Family Problems
- ☐ Sexual Problems
- ☐ Relationship Problems
- ☐ Long-Term Memory Problems
- ☐ Short-Term Memory Problems
- ☐ Wound Up or Tense More Days Than Not
- ☐ Obsessive Thoughts / Compulsive or Repetitive Behavior
- ☐ Panic Attacks
- ☐ Irritable
- ☐ Anxiety
- ☐ Muscle Tension
- ☐ Irrational Fear of Something or Someone
- ☐ Talking / Acting Without Thinking
- ☐ Fidgety, Restless, Overactive
- ☐ Difficulty Paying Attention
- ☐ Frequent Day Dreams
- ☐ Bored Easily
- ☐ Learning Difficulties
- ☐ Often Lose Things
- ☐ Excessive Dieting / Exercise
- ☐ Obsessed with Losing Weight
- ☐ Use of Laxatives
- ☐ Engage in Self-Induced Vomiting
- ☐ Eating Things That Are Not Food
- ☐ Vandalism / Fire-Setting
- ☐ Lack of Remorse for Wrongdoing
- ☐ Selfish
- ☐ Bullies / Gets in Fights
- ☐ Lying
- ☐ Truancy
- ☐ Theft
- ☐ Argumentative / Sudden Anger
- ☐ Defiant of Authority
- ☐ Temper Tantrums
- ☐ Stubborn
- ☐ Avoid Adults
- ☐ Afraid to Leave a Loved One
- ☐ Easily Embarrassed
- ☐ Upset by Minor Problems
- ☐ Feeling Detached from One's Body
- ☐ Feelings of Unreality
- ☐ See or Hear Things Others Don't
- ☐ Believe Things Others Tell You Aren't True
- ☐ Fear of Strangers
- ☐ Difficulty Trusting
- ☐ Believe Others are Out to Get You
- ☐ Intrusive Thoughts
- ☐ Avoid Things Related to Traumatic Event
- ☐ Startle Easily
- ☐ Flashbacks
- ☐ Nightmares

Please be aware that outpatient therapy may not be the appropriate level of care for you at this time based on the severity of what you are struggling with. We ask that you be completely honest with us about your symptoms so that we can either offer the best care or refer to a more appropriate level of care.

Other symptoms not mentioned previously:

How do your symptoms hinder your life?

Have you experienced any of the above mentioned symptoms in the past? If so, please describe:

Any history of substance abuse? ☐ Yes ☐ No

If no, please describe:

VIII. AUTHORIZATION

I authorize treatment deemed necessary by Bridge of Hope Counseling Services, P.C. I authorize Bridge of Hope Counseling Services, P.C to release to my health plan any and all information which is deemed necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Bridge of Hope Counseling Services, P.C for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Bridge of Hope Counseling Services, P.C. for all charges not paid by either my insurance companies and/or employer. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

_____ _____

Client Signature Date

Contractual Agreement between Client(s) and Bridge of Hope Counseling Services, P.C

Signature on File

My Signature(s) hereon authorizes Bridge of Hope Counseling Services, P.C to submit insurance claims to applicable insurance/EAP companies on my behalf and authorizes the release of any information necessary to process this claim to include release of medical records and payment authorization applicable to any current future treatment.

_____ _____

Client Signature Date

VIIII. PRE-AUTHORIZED HEALTH CARE FORM

I authorize Bridge of Hope Counseling Services, PC to keep my signature on file and charge my credit card account for:

- Charges for services rendered
- Charges for missed appointments (including those not canceled within 24 hours)
- Balances of charges not paid by me within 30 days

I understand that I will be notified before a charge is made.
I understand that I may revoke this agreement at any time by providing a request in writing.

CLIENT NAME
FIRST *LAST* *MIDDLE INITIAL*

CARDHOLDER'S NAME
FIRST *LAST* *MIDDLE INITIAL*

CARDHOLDER'S ADDRESS

CITY **STATE** **ZIP**

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

ACCOUNT NUMBER

EXPIRATION DATE **CVV CODE**

ZIP CODE ASSOCIATED W/CARD

Client Signature

Date

Bridge of Hope Counseling Services, P.C. agrees to charge only for reasons agreed upon in Psychotherapy.