

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			AIDDLE INITIAL
BIRTHDAY		AGE		GENDE	
MARITAL STATUS	SINGLE DATING MARE	RIED	PARTNERSHI		ARATED
ADDRESS					
СІТҮ			STATE	ZIP	
PHONE(S)	CELL PHONE		HOME PHONE		
EMAIL					

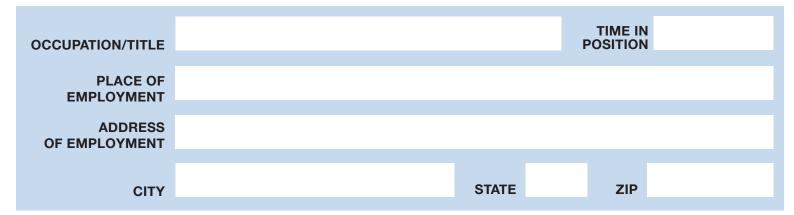
Authorization for Bridge of Hope Counseling Services, P.C. to:

Send mail to the address listed above	T YES	🗖 NO
Leave voice messages on the phone listed above	T 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:

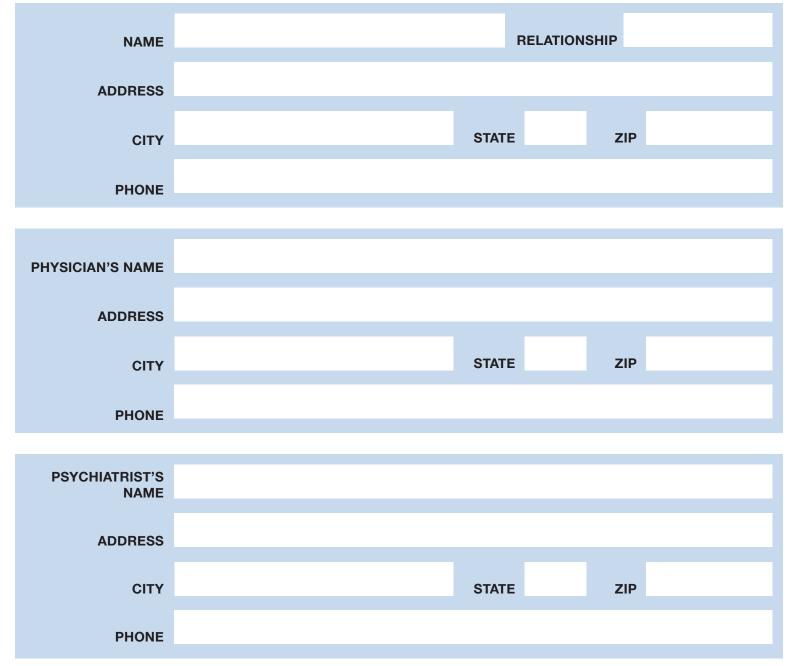
Name	Age	Occupation/Grade	Relationship	Living in Your Home?

II. EMPLOYMENT INFORMATION



III. EMERGENCY CONTACTS

In case of emergency, contact:



55 South 9th Street, East Alton, IL 62024 | Office: 618-216-3907 | Fax: 618-216-3908 | bridgeofhopecounseling.com

IV. REFERRAL SOURCE

How did you hear about us?

Facebook	Friend/Family Member	Physician/Psychiatrist
Psychology Today	U 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	LAS	ST		MIDDLE INITIAL
POLICY HOLDER'S ADDRESS					
			STATE	ZIP	
CITY					
POLICY HOLDER'S					
PHONE		DATE OI	FBIRTH		
RELATIONSHIP TO CLIENT					
CLIENT					
	DER'S INFORMATION:				
	JEN SINFORMATION.				
INSURANCE					
COMPANY					
I.D. NUMBER			GROUP NU	JMBER	
MENTAL/					
BEHAVIORAL					
HEALTH PHONE	(1-800 NUMBER ON BACK OF CA	RD)			

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 <u>PHYSICIAN</u> .	I decline to inform my <u>PHYSICIAN</u> .
Physician's	Name:	
Physician's	Phone #:	
Physician's	Address:	
Client Sign	ature (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 Sign	ature (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	Divorce/Separation	Moving
Marriage/Commitment	Becoming a New Parent	Job Change
Job/School Pressure	Major Illness	Legal Issues
Sexual Issues	Trauma	Finances
Family Issues	Death in the Family	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) Difficulty Paying Attention Feeling Sad / Crying Spells Frequent Day Dreams □ Too Little Sleep (Falling/Staying Asleep) Bored Easily □ Sleeping More Than Usual Learning Difficulties □ Fatigue / Loss of Interest or Pleasure Often Lose Things Avoiding Friends or Family Excessive Dieting / Exercise Expect Failure Obsessed with Losing Weight Decreased Concentration Use of Laxatives □ Thoughts of Death Engage in Self-Induced Vomiting Eating Things That Are Not Food Cutting / Burning Oneself Suicide Plan or Attempt Vandalism / Fire-Setting Depression Lack of Remorse for Wrongdoing Often Sick Selfish Loneliness Bullies / Gets in Fights □ Slow Moving Lying Hopelessness Truancy Confusion Theft Worthlessness Argumentative / Sudden Anger Lack of Confidence/Low Self-Esteem Defiant of Authority Guilt Temper Tantrums □ Stubborn Reckless or Dangerous Behavior Racing Thoughts Avoid Adults Inflated Self-Esteem Afraid to Leave a Loved One Marital/Family Problems Easily Embarrassed Sexual Problems Upset by Minor Problems Relationship Problems Feeling Detached from One's Body Long-Term Memory Problems Feelings of Unreality □ Short-Term Memory Problems See or Hear Things Others Don't Wound Up or Tense More Days Than Not Believe Things Others Tell You Aren't True Obsessive Thoughts / Compulsive or Repetitive Behavior Fear of Strangers Panic Attacks Difficulty Trusting □ Irritable Believe Others are Out to Get You Intrusive Thoughts Anxiety Muscle Tension Avoid Things Related to Traumatic Event Irrational Fear of Something or Someone □ Startle Easily Talking / Acting Without Thinking Flashbacks Fidgety, Restless, Overactive 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 s	substance abuse?
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If no, please describe:

🗖 No

Yes

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.

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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

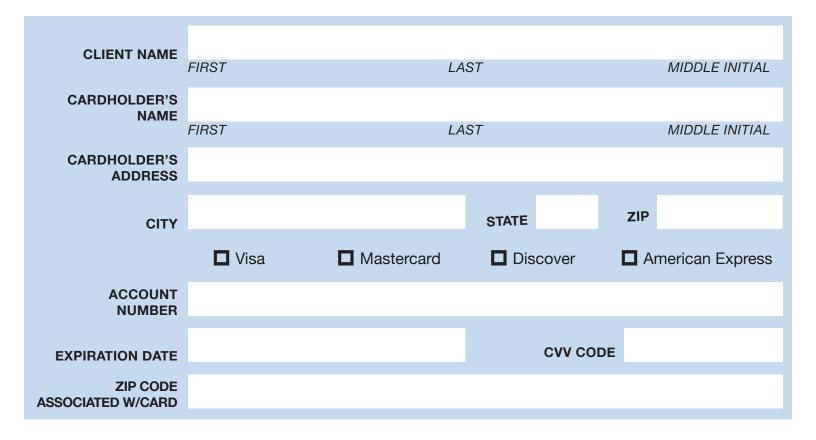
VIIII. PRE-AUTHORIZED HEALTH CARE FORM

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 Signature

Date

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

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