THERAPYWORKS NY
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Integrative Psychotherapist

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: The information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____

(Last) (First) (Middle)

Name Of Parent/Guardian(if under 18 years):

_____

(Last) (First) (Middle)

Birth Date: _____/_____/_____ Age: _____ Gender: ☐Male ☐Female

Ethnicity/Race:_____ Height:_____ Weight:_____

Marital Status:

☐Never Married ☐Domestic Partnership ☐Married ☐Separated
☐Divorced ☐Widowed

Please list any children/ages: _____

_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: (_____)_____-_____ May we leave a message? Yes No

Cell/Other Phone: (_____)_____-_____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Emergency Contact:_____

(Name) (Phone) (Relation)

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐Yes ☐ No

   If yes, please list previous therapist/practitioner: _____

2. Are you currently taking any medication? ☐Yes ☐No

   If yes, please list medications: _____

3. Have you ever been prescribed psychiatric medication? ☐Yes ☐No

   If yes, please list medication and dates: _____

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

   Poor Unsatisfactory Satisfactory Good Very Good

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

_____

5. 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: _____

_____

6. How many times per week do you generally exercise?

   _____

   What types of exercise do you participate in? _____

7. Please list any difficulties you experience with your appetite or eating patterns:

   _____

_____

8. Are you currently experiencing overwhelming sadness, grief or depression? Yes ☐No

   If yes, for approximately how long? _____

9. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐Yes ☐No

If yes, when did you begin experiencing this? _____

10. Are you currently experiencing chronic pain? ☐Yes ☐ No

    If yes, please describe: _____

11. Do you drink alcohol more than once a week? ☐Yes ☐No
12. How often do you engage in recreational drug use?

    ☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

13. Are you currently in a romantic relationship? ☐Yes ☐No

    If yes, for how long? _____

    On a scale of 1-10 how would you rate your relationship? _____

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

_____

_____

ADDITIONAL INFORMATION

Are you currently employed? ☐Yes ☐ No

If yes, what is your current employment situation? _____

Do you enjoy your work?_____

Is there anything stressful about your current work? _____

Do you consider yourself spiritual or religious? ☐Yes ☐No

If yes, please describe your faith or belief: _____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

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

_____

_____

FAMILY MENTAL HEALTH HISTORY

In this section below identify if there is a family history of any of the following. If yes, please indicate the family member's relation to you in the space provided (example: Father, Mother, Uncle, etc.) .

	Please Circle	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	

Notes: _____

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THERAPYWORKS

SCID SCREEN

Date (MM/DD/YY): _____

1. In the last month has there been a time you were feeling depressed or down most of the day, nearly every day?	1. Y N If N skip to 2.
a. Have you lost interest or pleasure in things that you usually enjoyed during the past month? b. Was it nearly every day?	1a. Y N 1b. Y N
2. Has there ever been a time when you were feeling depressed or down most of the day, nearly every day?	2. Y N If N skip to 3.
a. Have you lost interest or pleasure in things that you usually enjoyed during the past month? b. Was it nearly every day?	2a. Y N 2b. Y N
3. For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? (More than half the time?)	3. Y N
4. Have you ever had a period of time when you were feeling so good, "high", excited, or hyper that other people thought you were not your normal self or you were so hyper that you got yourself in trouble?	4. Y N If N skip to
a. Was it more than just feeling good? b. Did anyone else say you were manic? c. Was there ever a period of time when you were so irritable that you found yourself shouting at people or starting fights or arguments? d. Did you ever find yourself yelling at people you didn't really know?	4a. Y N 4b. Y N 4c. Y N 4d. Y N
5. Have you ever had a panic attack, when you suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms?	5. Y N
6. Were you ever afraid of going out of the house alone, being in crowds, standing in lines, or traveling on buses or trains?	6. Y N
7. Is there anything you feel uncomfortable doing in front of other people, like speaking, eating, or writing?	7. Y N
8. Are there any other things that you have been especially afraid of, like flying, seeing blood, getting shot, heights, closed places, or certain kinds of animals or insects?	8. Y N
9. Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?	9. Y N
10. Was there ever anything that you had to do over and over again, that you couldn't resist doing, like washing your hands again and again, counting up to certain numbers, or checking something several times to make sure that you'd don't it right?	10. Y N

11. In the last sick months, have you been particularly nervous or anxious?	11. Y N
12. Have you ever had time when you weighed much less than other people thought you ought to weight?	12. Y N
13. Have you often had times when your eating was out of control?	13. Y N
14. Sometimes things happen to people that are extremely upsetting- things like being in a life threatening situation like a major disaster, very serious accident or fire, being physically assaulted or raped; seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. At any time during your life, have any of these kinds of things happened to you? Which was the most upsetting?	14. Y N
15. Brief Description: _____ _____ _____ _____ _____ _____	

Notes: _____

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CURRENT PROBLEM CHECKLIST

Patient Name: _____ Date of Birth: _____

Date of Completing List: _____ Completed By: _____

Please check all that may apply in regards to currently experiences.

Marital/Relationship Problems	Problems on the job	Problem with children	Current problem with sexual abuse
Drug abuse	Feeling that you are not good	Losing pleasure in daily activities	Thinking about dying or killing yourself
Feeling sad or "down in the dumps"	Needing less sleep than usual	Trouble slowing down or talking less	Specific fear of a thing or place
Chest pains or discomfort	Feeling things that aren't there	Hot or cold flashes	Feeling trembly or shaking
Avoiding certain places or objects	Feeling anxious and nervous	Feeling urges to do something unnecessary	Recurring nightmares
Being troubled by painful memories	Physical Abuse	Losing someone or something close	Sexual abuse
Alcohol abuse	Feeling guilty about past misdeeds	Feeling the need to get more sleep	Often feeling restless or irritable
Trouble keeping your mind on a task	Preoccupied with sexual thoughts or urges	Spending spree	Fear of crowds or public places
Heart palpitations	Troubled by repetitive thoughts	Worrying about things over and over	Feeling emotionally numb
Frequently feeling startled	Feeling aches and pains	Often feeling sick	Problems with memory
Having trouble remember past	Feeling that I lost time	Urge to set fire	Feeling anger or resentment
Vomiting to control calorie intake	Fasting in order to control weight	Extreme changes in my weight	Fear of having or getting a disease
Getting lost or confused	Finding things I don't remember having	Urge to harm self or others	Difficulty controlling temper
Taking laxative to control weight	Exercising frequently and vigorously	Feeling helpless about my eating habits	Feeling dizzy or unsteady

Please list any other problems not mentioned above. _____

_____

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health records contain personal information about you and your health. This information about you that may identify you and relates to your past, present or future physical or mental health or conditions and related to health care services is referred to as Protected Health Information ("PHI"). This notice of Privacy Practices describes how we may use and disclose you PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain PHI's privacy and provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of out Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFROMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consulting with clinical supervisors or other treatment team member We may disclose PHI to any other consultant only with your authorization. We may use or disclose your PHI, as necessary, to remind you of your appointment. Also, we may contact you to provide information about health related benefits and services offered by our office.

For Payment: We may use and disclose PHI to receive payment for your treatment services. This will only be done with your authorization. Examples of payment-related activities are deciding of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for collection purposes.

For Health Care Operations, We may use or disclose, as needed, your PHI to support our business activities, including, but not limited to, quality assessment, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share PHI with third parties that perform various business activities(e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.

Required by Law: We must disclose your PHI upon your request and to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the Privacy Rule.

Abuse and Neglect: We may disclose you PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose you PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, this disclosure will be made in a manner that is consistent with the requirements of applicable federal and state law.

Judicial and Administrative Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding in response to an order of a court.

Serious Threat to Self or Others: If you communicate a specific threat of imminent harm against another individual or if there is reason to believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. Suppose there is reason to believe that you present an imminent, serious risk of physical or mental injury or death to yourself. In that case, we may make disclosures that we consider necessary to protect you from harm.

Family Involve in Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present to agree or object to the use or disclosure of the PHI, then Shirley Taylor Dunn may, use professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your healthcare will be discussed.

Law Enforcement: We may disclose PHI, as long as applicable legal requirements are met, for law enforcement purposes.

Public Safety: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen serious and imminent threat to the health or safety of a person or public. We may also disclose PHI, if it is necessary for law enforcement authorities, to identify or apprehend the individual.

Workers' Compensation: Your PHI may be disclosed as authorized to comply with workers compensation laws and other similar legally established programs.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and discloses not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOU PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Therapy Works, _____.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost based fee for the copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosure that we make of you PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosures of your PHI or treatment, payment, or healthcare operations. We are not required to agree to your request.
- **Rights to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

NOTICE OF PRIVACY

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Shirley Taylor Dunn's Notices of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy right, I can contact Shirley Taylor Dunn 347-993-7124.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare, surrogate, etc.)*

☐ Patient/Client Refuses to Acknowledge Receipt

_____

Signature of Staff Member Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

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

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social services and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (When applicable)

Insurance companies and other third-party payers are given information they request regarding client services. Information that may be requested includes type of services, dates/time of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

CANCELLATION POLICY

Thank you for your consideration and cooperation regarding this critical matter.

All scheduled appointments require a 24-hour notice of cancellation. If you fail to cancel a scheduled appointment, we cannot use this time for another appointment. A full fee will be charged for missed appointments or no-show cancellations with less than 24 hours of notice. You will receive a payment request via text message or email. A bill may also be mailed directly to all clients who do not attend or cancel an appointment.

I appreciate your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date