Four Feathers Counseling

332 W Bijou St Suite 103
Colorado Springs, CO 80905
Office/Fax 855.332.3466

Client Intake Questionnaire

In order to provide the best clinical service to you please provide information to the questions listed below to the best of your ability.

Client Name:		Date:
DOB:	Age:	Social Security #:
Mailing Address:		
Physical Address:		
Home Phone:	Cell:	Email:
Preferred Method of Contact: [ ] Call Home [ ] Text Cell [ ] Call Cell [ ] Email Appointment Reminders: [ ] Call Home [ ] Text Cell [ ] Call Cell [ ] Email		
Employer / School:		
Insurance Carrier:		Policy #:
Name of Primary Person Responsible for Insurance:		
Primary Person's Date of Birth:		Social Security #:
Primary Person's Employer:		
Client's Religious / Spiritual Background:		
Referred By:		
Reason for Referral:		
What goals / outcomes would you like to see as a result of participating in therapy:		

Client Name:

Family Members in the Home		
Name	Age	Relationship to the Client

Major Accidents, Illnesses, Head Injuries and Seizures:
Current Medical Problems:

Current Medications:	Dosage:	Prescribing Doctor:

How often do you drink wine or alcohol?

Please list any other current substances you are using:

Last Physical / Results:

Are You Experiencing Any of the Following:	
[ ] Nervousness / Shakiness	[ ] Feeling Everything is an Effort
[ ] Feeling Sad or Blue	[ ] Feeling Fearful or Afraid
[ ] Feeling Hopeless	[ ] Difficulty at Home
[ ] Trouble Sleeping	[ ] Difficulty at Work or School
[ ] Decreased Appetite	[ ] Physical Pain

Client Name:

Family History

Mental Health Problems:

Attention Problems:

Substance Abuse:

Legal History:

School / Employment History:

History of Abuse (Emotional, Physical, Sexual, Verbal & Domestic Violence):

Individual and Family Strengths:

Pregnancy / Developmental / Medical History: (Skip if you are an adult seeking therapy for yourself)

Problems with Pregnancy, Delivery:

Early Development (Age Crawling, Walking, Potty Trained and Speaking) List Any Delays:

Discipline used with children:

Therapist: _____
Credentials: _____
Contact Information: _____
Email: _____

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Disclosure Statement

Colorado law requires that all psychotherapists provide certain information to all clients at the initial consultation.

Supervisor: _____

Professional Affiliations: _____

Regulation of Psychotherapists:

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Masters degree in their profession and have two years of post-Masters supervision. A Licensed Psychologist must hold a Doctorate degree in psychology and have one year of post-Doctorial supervision. A Licensed Social Worker must hold a Masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Masters degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the State and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the State.

Client Rights and Important Information:

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee. Please ask if you would like to receive this information.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, certifies or registers the therapist.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent psychical harm by a client to law enforcement and to the person(s) threatened. (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.
- Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

Disclosure Regarding Divorce and Custody Litigation:

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

Continued

Client Name: _____

Disclosure and Information Statement

HIPAA - Patient Privacy Practices

Four Feathers Counseling, Inc has made every effort to be compliant with the Protected Health Information (PHI) requirement set forth in the Health Insurance Portability and Accounting Act (HIPPA) of 1996. You have received a *separate* document entitled Notice of Privacy Rights. By signing this information sheet you acknowledge that you have been provided a copy of Four Feathers Counseling's Notice of Privacy Rights.

Practice Information

In the event Four Feathers Counseling, Inc is a contracted provider with your insurance, FFC has agreed to accept their managed care rates and will provide billing services for your convenience. Required insurance forms will be provided at no cost to you. However, you are responsible for your co-payment at each session. In the event that your insurance declines payment of services you have received, you will be responsible for payment. It is your responsibility to contact your insurance to determine if prior authorization is needed.

Waiting: Please wait in the waiting room area. Feel free to let your children play with the toys in the waiting area.

Therapy Canine: Four Feathers Counseling has a therapy dog on the premises. If you or your family member has an allergy or unease with dogs please notify your therapist so arrangements can be made.

I have read the proceeding information and understand my rights.

Client Signature **Date**
Parent or Guardian under age of 12 years

Client Signature **Date**
Parent or Guardian under age of 12 years

If signed by Responsible Party, identify that person's legal authority to consent to treatment: _____