Harmony Counseling Services

257 Main St. Harmony, PA 16037

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Today's Date ________________________________

Referral Source ______________________________

Client Information

Name

____

Last   First   Middle

Age _________**Date of Birth** _______________________ **Sex (circle one)** Male Female

Marital Status (circle one) Single Married Divorced Separated Widowed Partnered

Name of Spouse/Partner: ____

Children Names, Ages, and Where Residing (if applicable):

____

____

Mailing Address

____

Street   City   State   Zip

Home Phone _(_____)________ **Work Phone** _(_____)_______ Cell _(____)__________

Email Address

____

Please be aware that email might not be confidential.

Employment Status (circle one) Full-Time Part Time Unemployed Student

Occupation ___________________________ Employer __________________________________

Highest Level of Education

____

In Case of Emergency:

Name ____

Relationship to you ________________**Home Phone** _(____)________________

Cell _(____)___________

Insurance Information

Primary Insurance _________________________________ **ID Number**____________________

Primary Insured's Name ____________________________ **Date of Birth**__________________

Client's Relationship to Insured □ Self □ Spouse □ Child □ Other

Secondary Insurance (if applicable) ___________________**ID Number** ___________________

Secondary Insured's Name ___________________________**Date of Birth** __________________

Client's Relationship to Insured □ Self □ Spouse □ Child □ Other

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History

Have you had prior counseling? If so, when and with whom?

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____

Current/previous mental health diagnosis

____

Current medications, dosages, and who prescribed

____

____

How would you describe your physical health? Please list any physical conditions/symptoms you have.

____

____

Are you having any problems with your sleep habits? If yes, please describe.

____
____

How many times a week do you exercise?

____

Primary Care Physician and phone number ___(____)________________________

Do you have a family history of mental illness or substance abuse? If so, please explain.

____
____

Describe your current use of alcohol and/or drugs.

____
____

Please list any previous hospitalizations/in-patient treatment (hospital/treatment facililty, date, reason for admission)

____
____

Do you currently have any thoughts or feelings of wanting to physically harm yourself? If so, explain.

____
____

Have you ever been sexually abused, or do you suspect you may have been?

____

Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship/marriage?

____

If yes, on a scale of 1-10 with 10 as best, how would you rate the quality of your relationship? ___

In the past year, have you experienced any significant life changes or stressors?

____
____

Do you consider yourself to be religious or spiritual? □ No □ Yes

If yes, please describe.

____

What do you consider to be your strengths? (personal, family, vocational, recreation, social, cultural, community resources, etc.)

____

____

Is your current issue affecting your academic, work, or social functioning? Please explain.

____

____

____

Please list your goals and expectations for counseling.

____

____

____

____

____

____

For Couples Counseling only

Please indicate your own personal goal for couple therapy. Please do this independently of your partner.

1. My goal is: □ Improve the relationship □ Clarify whether the relationship should continue

□ End the relationship in the best possible way

□ Other: ____

2. Do you think your partner is in agreement with your goal? □ Yes □ No

Symptom Checklist

Please check the following words or phrases you feel apply to you or your life:

□ Headaches □ Guilt □ Sexual concerns

□ Heart Palpitations
□ Drug Use
□ Shy
□ Feelings of Worthlessness
□ Indecisive
□ Feelings of panic
□ Unable to relax
□ Trembling
□ Confused
□ Hopeless
□ Things seem surreal
□ Relationship issues
□ Anxiety
□ Fatigue
□ Parental concerns
□ Illness of a family member
□ Difficulty keeping a job
□ Poor academic performance
□ Sleep problems
□ Restless
□ Regrets from past

□ Stomach/digestive issues
□ Excessive worry
□ Few friends
□ Disturbing thoughts
□ Poor concentration
□ Angry
□ Recent loss(es)
□ Impulsive
□ Irritability
□ Eating Disorder
□ Memory problems
□ Financial problems
□ Nightmares
□ Feelings of emptiness
□ Poor appetite
□ Dizziness
□ Lonely
□ Nervous
□ Fainting spells
□ Depressed
□ Moody

□ Fear
□ Chronic pain
□ Abusive behavior
□ Other, please list:

This form contains important information about your upcoming counseling. Please read, and add your signature and date at the bottom.

Confidentiality: All written information pertaining to your visits is strictly confidential and CANNOT be released to anyone, including family, spouses, attorneys, etc. without your written consent. Exceptions to this are made only if you are in imminent danger of harming yourself or

someone else. Additionally, counselors are required by law to report child or elderly abuse and to release records ordered by a court judge.

About HCS: Harmony Counseling Services is a professional counseling group practice offering highly effective confidential care for individuals and families experiencing a range of mental health challenges.

Services Available: Individual (child-adolescent-adult), family, couple, and group counseling (groups determined upon need and counselor availability).

Initial Session: Your initial evaluation will be utilized for exploring your concerns and discussing what services will be useful. We fully enlist the client in the development of their treatment plan. From the initial contact we actively involve them in implementing a plan of solving problems, creating solutions, and achieving treatment goals.

Fees and Payment: The basic fee is $100 per 50 minute individual session, $125 for the initial assessment and for children, couples, and families. Rates for groups vary. Payment is requested at the time services are rendered and may be by check, cash, or credit card. Blue Cross Blue Shield insurance is accepted as well as Self-Pay. When using your insurance, please note insurance companies requires a DSM-IV code to represent your diagnosis; they will not reimburse without that code. Any personal information or diagnosis provided to an insurance company can no longer be held to the same standard of confidentiality, and may become part of your permanent insurance record.

Cancellations: Cancellations less than 24 hours will be charged full fee. Please schedule carefully.

Emergencies: If you have an urgent situation, which you feel needs immediate support, please contact your family physician, or call your county's mental health hotline:

Butler: 1-800-292-3866 Beaver: 1-800-400-6180 Allegheny (Resolve): 1-888-796-8226

…or go to the nearest emergency room and ask for the psychologist/psychiatrist on call. In the event of a life-threatening emergency call 911.

Questions or Concerns about the therapeutic process: If, at any time, you feel my behavior or my counseling approach is inappropriate or troubling to you, please let me know. If, however, you do not feel your concerns are being addressed appropriately, feel free to contact the following:

State Board of Social Workers, Marriage and Family Therapists and Professional
Counselors P.O. Box 2649, Harrisburg, PA 17105-2649
or by Phone at (717) 783-1389

Informed Consent: "I have read the above information, understand it, and agree to the conditions. I have read all office policies and understand my responsibilities. Furthermore by way of my signature, I provide ___Harmony Counseling Services___with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as stated in the Privacy Policy."

___________________________________ **Date:** _______________________________

Patient's Signature or Guardian/Parent

____

Print Patient Name

List of Medications

Medication	Dosage	X per day	Reason

Outcome Rating Scale (ORS)

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually

(Personal well-being)

|--|

Interpersonally

(Family, close relationships)

|--|

Socially

(Work, school, friendships)

|--|

Overall

(General sense of well-being)

|--|