Harmony Counseling Services

257 Main St. Harmony, PA 16037

Dennis Curcio, MA, NCC, LPC Maria Kitay, MSED, NCC, LPC

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Today's Date _____

Referral Source _____

Client Information

Name

_____

Last First Middle

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

Mailing Address

_____

Street City State Zip

Home Phone _(_____)_____ **Parent's Work Phone** _(_____)_____

Parent's Cell _(____)_____

Parent's Email Address

_____

Client's Email (if applicable)

_____

Please be aware that email might not be confidential.

Names, ages, and where residing of siblings (if applicable):_____

_____

Parent Names: Marriage Status: Married Separated Divorced Widowed

_____

Parent's Occupation _____ Client's Occupation _____

Current Grade Level_____

Name of School _____

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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In Case of Emergency

Name of Local Friend or Relative (not living with you) _____

Relationship to you _____Home Phone _(____)_____ Cell _(____)_____

History ***(Please have child/adolescent complete the following, if possible)***

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

_____

_____

Current/previous mental health diagnosis

_____

Current medications, dosages, and reason

___***Please see grid/form at end of intake paperwork***_____

How would you describe your physical health?

_____

Are you having any problems with your sleep habits? □ No □ Yes

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 facility, 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? _____

Have you ever been diagnosed with an eating disorder? If so, please describe.

_____

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

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

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,)_____

_____

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

_____

_____

Please list your goals and expectations for counseling.

_____

_____

<u>If you would like to expand on answers please do so here</u>

Symptom Checklist

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

□ Headaches	□ Guilt	□ Sexual concerns
□ Heart Palpitations	□ Stomach/digestive issues	□ Fear
□ Drug Use	□ Excessive worry	□ Chronic pain

□ Shy	□ Few friends	□ Abusive behavior
□ Feelings of Worthlessness	□ Disturbing thoughts	□ Other, please list:
□ Indecisive	□ Poor concentration	----------
□ Feelings of panic	□ Angry	----------
□ Unable to relax	□ Recent loss(es)	----------
□ Trembling	□ Impulsive	
□ Confused	□ Irritability	
□ Hopeless	□ Eating Disorder	
□ Things seem surreal	□ Memory problems	
□ Relationship issues	□ Financial problems	
□ Anxiety	□ Nightmares	
□ Fatigue	□ Feelings of emptiness	
□ Parental concerns	□ Poor appetite	
□ Illness of a family member	□ Dizziness	
□ Difficulty keeping a job	□ Lonely	
□ Poor academic performance	□ Nervous	
□ Sleep problems	□ Fainting spells	
□ Restless	□ Depressed	
□ Regrets from past	□ Moody	

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 due at the time services are rendered and may be by check or cash. When using your insurance, please note insurance companies requires a DSM-V 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 (or no-shows) less than 24 hours will be charged $70 of session 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 regarding therapeutic process: If, at any time, you think my counseling approach is not congruent with your expectations, 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."

_____ _____

Patient's Signature or Guardian/Parent **Date**

_____

Print Patient Name

Child Outcome Rating Scale (CORS)

Name _____Age (Yrs):____

Sex: M / F_____

Session # ____ Date: _____

Who is filling out this form? Please check one: Child_____ Caretaker_____

If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. If you are a caretaker filling out this form, please fill out according to how you think the child is doing.

Me

(How am I doing?)

I----------I

Family

(How are things in my family?)

I----------I

School

(How am I doing at school?)

I----------I

Everything

(How is everything going?)

I----------I

The Heart and Soul of Change Project

List of Medications

Medication	Dosage	X per day	Reason
