MASTERPEACE

Center for Counseling and Development

CLIENT INTAKE QUESTIONNAIRE

This information is very important to understand as much as possible about you and your situation in order to meet your specific treatment needs. Thank you for your help.

Client Name ____

Name of person filling out form if different than client ____

What are your reasons for seeking treatment at this time?

Have you had mental health counseling:

Outpatient: **No Yes** Where, for how long.

Inpatient: **No Yes** Where, for how long.

Substance Abuse treatment

Outpatient: **No Yes** Where, for how long.

Inpatient: **No Yes** Where, for how long.

Are there any relatives with a history of an emotional problem or substance abuse? **No Yes** If yes, describe.

Are you attending any self-help groups? **No Yes** If yes, describe.

Occupational/Educational History: *Please Circle*

Student   Not Employed   Self Employed   Employed: Full Time   Part Time

Satisfaction with School or job: **No Yes** If no, describe:

Highest schooling completed:

Military History:

Branch	**Rank**	**Time in service**	**Active combat**

Developmental History for Children clients only:

The pregnancy with this child was normal. If not please explain:

Was the child: *Circle one:* Full term or Premature

Where there any difficulties as a baby with the following:

Feeding	Yes	No	Weight gain	Yes	No
Sleeping	Yes	No	Weaning from breast/bottle	Yes	No
Crying	Yes	No	Toilet training	Yes	No

What age did your child do the following?

Sit ______   Crawl _____   Walk _____   First word _____   Simple sentence _____

Have there been any significant events which have had a negative effect on your child: **No Yes** If yes, please explain.

Family Members:

Names, ages, and sex of all people living in home.

Names, ages, and sex of children NOT living in home.

Who do you feel gives you the most emotional support:

Circle which happened in your life: separation, divorces, deaths, etc.: Please explain.

Please circle Yes or No below:

	Childhood years Emotionally close	**Adult years** Emotionally close	Comments
Bio Mother	Yes No	Yes No	
Step-Mother	Yes No	Yes No	
Bio Father	Yes No	Yes No	
Step-Father	Yes No	Yes No	
Brothers	Yes No	Yes No	
Sisters	Yes No	Yes No	
Friends	Yes No	Yes No	
Current spouse	xxxxxxxxxxxx	Yes No	
Ex-Spouse	xxxxxxxxxxxx	Yes No	

Medical History:

The year of your last physical exam:

Have you had any health Issues, serious accidents, or hospital admission? Circle: **No Yes** If yes, describe.

#of Pregnancies ______ Live births _____ Other _______

Do you have any allergies? **No Yes** If yes, describe.

List all **prescribed** medications you are taking: Include dose and condition used for.

Medication:	**Dose:**	**Condition:**

Circle all over- the counter use of: vitamins, minerals, diet pills, supplements, herbs, other: _______________________

Have you ever had a problem with overuse of prescribed medications? **No Yes** If yes, describe.

Name ____Date ______________

Have you ever:	PAST	PRESENT	Comments
Had thoughts of suicide?	Yes No	Yes No	
Attempted suicide?	Yes No	Yes No	
Thoughts of hurting yourself?	Yes No	Yes No	
Wanted to hurt someone else?	Yes No	Yes No	

General/Do you have any difficulty with the following problems?

	No	Mild	Moderate	Severe	How Often/Comments
Depressed Mood					
Hopeless/Helpless					
Crying Spells					
Apathy, Lack of Interest					
Changes in Appetite					
Irritability					
Shame or guilt					
Low Self Esteem					
Cutting/Hurting Yourself					
Mood Swings					
Impulsive, Illegal, Reckless behavior					
Anger or Outburst					
Poor Concentration					
Restless/Fidgety					
Easily Distracted					
Poor Memory					
Hearing Voices					
Anxiety/Panic					
Fears/Phobia					

Eating Habits	Y	N
3 meals a day		
Poor appetite		
Increased appetite		
Weight Loss/Gain		
Bingeing/purging		
Laxatives/diuretic		

Sleeping Patterns	Y	N
Average night sleep		
Difficulty falling asleep		
Wakes up early		
Interrupted sleep		
Use of sleep aids		
Nightmares		
Excessive sleeping		

Diet	Y	N	Daily Amounts
Healthy			
Poor			
Coffee			
Tea			
Soda/pop			
Other Caffeine			

Substance	Used within last 2 days?	How often used?	Year first used?	When last used?
Cigarettes/tobacco				
Alcohol				
Sleeping pills				
Marijuana				
Inhalants				
Cocaine/Crack				
Heroin				
Other				

Leisure Activities:
List some of your hobbies, activities, or talents.

How important is your spiritual life to you? (circle) Very Somewhat Not very

Church attended: _____________________________ Frequency (circle) Weekly Occasionally

Legal History:
Do you have any pending or prior legal issues i.e., bankruptcy, arrests, etc. **No Yes** If yes, describe.

If client is a child - who has legal custody:
Please provide therapist with a copy of any custody agreements or guardianship papers.

Other:
Have you ever been a victim of:

	Yes	No	From Who and When:
Physical abuse			
Sexual abuse			
Emotional abuse			
Verbal Abuse			

Is there anything else you think we ought to know about yourself? **No Yes** If yes, describe.

Client Goals: Before you see the therapist, please list some ideas regarding the following question:
What do I want or expect to accomplish in therapy?

Name ____**Date** _____________

Pre Counseling Questionnaire

Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale given below, please respond to each item. Do not leave any blank. For each question, please fill in only **one number.**

0 = No difficulty or N/A **1 = A little difficulty** **2 = Moderate difficulty** **3 = Quite a bit of difficulty** **4 = Extreme difficulty**

What best describes the degree of difficulty you have been experiencing in each area during the PAST WEEK:

1. Managing Day-to-Day Life making decisions (*Please Circle:* getting places on time, handling money, other____________________________). 1_____
2. Household responsibilities (*Please Circle:* shopping, cooking, laundry, cleaning, home maintenance, yard care, other chores ________________________). 2_____
3. Work (*Please Circle:* completing tasks, performance level, finding/keeping a job). 3_____
4. School (*Please Circle:* academic performance, completing assignments, attendance). 4_____
5. Leisure time or recreational activities. 5_____
6. Adjusting to major life stresses (*Please Circle:* separation, divorce, moving, new job, new school, a death, other____). 6_____
7. Relationship with family members. 7_____
8. Getting along with people outside of the family. 8_____
9. Isolation or feelings of loneliness. 9_____
10. Access to social system (e.g. Church, friends, support group, clubs). 10_____
11. Are you able to feel close to others? 11_____
12. Are you being realistic about yourself or others? 12_____
13. Recognizing and expressing emotions appropriately. 13_____
14. Developing independence. 14_____
15. Feeling satisfaction with your life, making goals or direction in life. 15_____
16. Physical symptoms (*Please Circle:* headaches, aches and pains, stomach aches, dizziness, other____). 16_____
17. Uncontrollable, repetitive behavior (*Please Circle:* eating disorder, hand-washing, hurting yourself, counting, gambling, other____). 17_____
18. Disturbing or unreal thoughts or beliefs. 18_____
19. Extreme energy or racing thoughts and/or lack of need for sleep for more than one night in a row. 19_____
20. Sexual activity or preoccupation with (*Please circle:* pornography, internet relationship, other____). 20_____
21. Other sexual problems (lack of desire, physical issues). 21_____

Client or guardian Signature: _______________________ Date: _____________

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CLIENT CONTACT AND BILLING INFORMATION

Client Name: ____ SSN ________________________

Client or parent
Home phone: _____________________ Cell # _____________________ Work # ______________________
Ok to leave a message Y N Ok to leave a message Y N Ok to call Y N

Spouse or other parent:
Home phone: _____________________ Cell # _____________________ Work # ______________________
Ok to leave a message Y N Ok to leave a message Y N Ok to call Y N

For Children:
Parents/Guardians Name & DOB: ____

Street Address: ____

Mailing Address *if different*: ____

Emergency contact person (name, relationship, and phone #): ____________________________________
****

Please *Circle* form of payment: INSURANCE CASH

If cash please identify who is responsible for payments *if other than client*: ____________________________

________________	________________	________________	________________
Primary Insurance	Policyholder's name	Relationship to client	Policyholder DOB
________________	________________	________________	________________
Contract/ID Number	Group Number	Policyholder's Employer	Policyholder SSN

________________	________________	________________	________________
Secondary Insurance	Policyholder's name	Relationship to client	Policyholder DOB
________________	________________	________________	________________
Contract/ID Number	Group Number	Policyholder's Employer	Policyholder SSN

________________	________________	________________	________________
Third Insurance	Policyholder's name	Relationship to client	Policyholder DOB
________________	________________	________________	________________
Contract/ID Number	Group Number	Policyholder's Employer	Policyholder SSN

MASTERPEACE
Center for Counseling and Development
"A Trusted Name in Christian Services"

CONFIDENTIALITY CONSENT-COORDINATION OF CARE FORM

CONFIDENTIALITY STATEMENT:
As professionals, we maintain and safeguard the confidential nature of the information obtained within the treatment or testing relationship. All records, communications, treatment and testing information pertaining to each client will be treated as private and confidential matters as governed by Section 748 of the State of Michigan Mental Health Code, Act 25. However, MASTERPEACE will communicate information that would otherwise be confidential under the following circumstances, which are **exceptions to the general policy of confidentiality:**

1. Client has given MASTERPEACE written permission to discuss his/her case with another person or agency.
2. Masterpeace becomes aware of serious threats (suicidal or homicidal) to the personal safety of someone.
3. Masterpeace receives information indicating, suspecting or substantiating (sexual or physical) abuse, neglect or exploitation of a child, aged adult, or persons vulnerable as a result of mental disability or functional illiteracy.
4. Masterpeace is ordered to do so by a court of law.
5. When necessary for periodic case review with other Masterpeace staff for purposes of supervision and consultation.

CONSENT FOR TREATMENT or TESTING
I give MASTERPEACE permission to provide treatment or testing to myself and/or other individuals deemed necessary for my mental health care. I understand that my participation at MASTERPEACE is voluntary and that this Consent for Treatment or Testing will remain in effect for the duration of this treatment or testing period unless I revoke my consent in writing. In addition, I understand that the treatment outcome is different for each individual and cannot be guaranteed.

COORDINATION OF CARE BETWEEN MASTERPEACE AND CLIENT'S PHYSICIAN
IF you as a client need Masterpeace to contact your Primary Care Physician (PCP) about your treatment, please indicate your authorization for Masterpeace to release information to my PCP of my visit(s) and treatment plan by completing the PCP's name, address and phone number below.

PCP's name: ________________________________ Phone: ________________________

Address: ____

RECEIPT of NOTICE OF PRIVACY POLICY
My signature below also indicates I have received a copy of MASTERPEACE Center for Counseling & Development's Notice of Privacy Practices.

I, the undersigned have the legal authority to consent to treatment; have read the above statements and discussed it with my therapist who has fully answered any of my questions regarding Notice of Privacy Policy, Confidentiality, and Consent to treatment or testing as recommended by MASTERPEACE.

If the client is a minor the person signing below has legal authority to consent for treatment or testing and will inform MASTERPEACE immediately if that authority changes.

____ ____________________
Signature (Parent or Guardian must sign if client is under 18 years old) Date

____
Print Client's Name (if different than the person signing above)

Revised 08/96, 07/98, 2/00, 5/02, 7/03, 3/04, 11/05, 10/06, 06/11, 3/12

MASTERPEACE Center for Counseling and Development

308 South Maumee Street • Tecumseh, Michigan 49286

CLIENT COPY FEE AGREEMENT

MASTERPEACE charges fees for each session and according to the professional providing the services.
The fee schedule is as follows:

COUNSELING	**Initial session fee**	**Follow-up fee**
Master's (LMSW)	$120	$100
PhD/ Supervised LMSW	$150	$120
Late Cancel/No Show Fee		$40
TESTING	**2 Hour Fee**	**4 Hour Fee**
PhD/ Supervised LMSW	$260	$510
NEUROFEEDBACK	**1 Visit**	**10 Prepaid Visits**
PhD	$75	$600

Administrative fee (e.g. other professional communications or correspondence)
$100 per hour for MSW
$120 per hour for PhD

A 45 to 50 minute session will be **charged at** the **applicable amount above.** The Client, Parent or Guardian listed below will be responsible for paying all co-pays, deductibles and other charges as required by the insurance company.

The Client, Parent, or Guardian understands that the "usual and customary" rate approved by the insurances is not a guarantee of payment. The client's actual out-of-pocket expense may be more than the co-pay amount alone (i.e. deductible must be met in full). The client further understands that any insurance benefits received by MASTERPEACE will be credited to the client's account and that if the insurance company pays the client directly the client will owe MASTERPEACE the entire amount.

Masterpeace Counseling reserves the right to charge the Late Cancel/No Show Fee of $40.00 if the client neglects to cancel an appointment 24 hours in advance.

Medicaid Clients: Client, Parent, or Guardian will be responsible for payment of fees that are not a covered benefit of the Medicaid plans. (Example of non-covered services: any court ordered counseling, Late Cancel/No Show fee of $40.00, or sessions beyond what Medicaid authorizes, etc…)

The client, parent, or guardian agrees to accept full responsibility for payment for all services rendered, including deductibles, co-pays, and any amount denied by the insurance company.

RELEASE OF INFORMATION FOR REIMBURSEMENT OF SERVICES

MASTERPEACE will release information to the client's insurance company or any other entity providing reimbursement of services:

1. To determine eligibility and process claims for benefits submitted on behalf of the client or the client's dependents.
2. This signature will bind the client to authorize the Therapist to submit claims for services rendered, without having to obtain the client's signature on each and every claim.
3. To authorize the client's insurance company or any other entity providing reimbursement of services to pay and assign directly to MASTERPEACE all benefits for services as described.

CLIENT'S APPROVAL OF FEES AND RELEASE OF INFORMATION

I, the undersigned, have discussed the above terms with the professional, who has fully answered my questions. I acknowledge that I have the legal authority to agree to the above terms and will inform MASTERPEACE immediately if the authority changes.

_______________________________ _______________________

Signature of Client, Parent or Guardian Date

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*** MASTERPEACE COPY ***

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