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Serenity Trauma Healing Center

Intake Assessment

Client Name: _____ Date_____ Case Number: _____

Date of Birth_____

Social Security Number_____

Gender: Male, Female, Bi-sexual, Homosexual, LGBT, LGBTAQ

Address: _____

City: _____State_____ZIP_____

Phone: Home: _____

Cell: _____

May we leave a message at home? Yes_____No_____

E-Mail Address_____May we e-mail you? Yes_____NO_____

Person to notify in case of an Emergency_____

Phone Number_____

What is your sexual orientation? Straight___ Heterosexual___ Bi-sexual__ A- sexual transsexual__ transgender__ LGBT__ LGBTQ__ LGBTQIA_-

Please list any children /age: _____

Are you employed? Yes_____No_____

Referred by: _____

What is the main reason you are seeking treatment today? _____

What are your goals for therapy? _____

What do you consider your strengths to be? _____

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

_____

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Client Name:_____

I. IDENTIFYING DATA (ID): This client is a _____Y.O. ☐ white ☐ black ☐ multi-racial ☐ other_____
☐ single ☐ widowed ☐ married ☐ divorced ☐separated ☐ male ☐ female
employed as a_____. Referred by:_____

II. CHIEF COMPLAINT (CC): In client's own words, state client's reason for seeking treatment at this time.

III. DSM IV SYMPTOMS:_____

IV. HISTORY OF PRESENT ILLNESS (HPI): Chronological narrative describing symptoms, impairment, and other data indicative of psychopathology. Discuss precipitating events, intensity of symptoms, duration, and why the client is seeking treatment at this time. This section should substantiate your Axis I and Axis II diagnosis

V. SIGNIFICANT RELATIONSHIPS:_____

VI. SIGNIFICANT GRIEF/TRAUMA EXPERIENCES:_____

VII. PHYSICAL ABUSE/SEXUAL ABUSE HISTORY:_____

VIII. LEGAL HISTORY:_____

IX. SOCIAL ACTIVITY HISTORY:_____

Client Name:_____

X. PHYSICAL, MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY:

A. MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT HISTORY:

1. PATIENT (Diagnosis, outpatient treatment, hospitalizations, treatment outcomes, etc).

☐ No History.

Elaborate, if present

_____

_____

_____

_____

_____

2. FAMILY History of Mental Health/Substance Abuse Problems (e.g. phobias, suicide, psychiatric hospitalizations, manic-depressive illness, schizophrenia, anxiety, depression, eating obsessive compulsive behavior, ect)

☐ No History. Elaborate, if present

_____

_____

_____

_____

B. MEDICAL HISTORY

Sleep Status ☐ Adequate ☐ Inadequate _____

Exercise Status ☐ Adequate ☐ Inadequate _____

Nutritional Status ☐ Adequate ☐ Inadequate _____

Current Medical Problems: _____

_____

_____

Past Medical Problems: _____

_____

_____

Past Medication and effectiveness (Prior 6 months)_____

_____

_____

_____

Client Name:_____

Current Medications and effectiveness_____

_____

_____

_____

_____

_____

Have you had any medication allergies and or adverse reaction to medications? _____

XI. SUBSTANCE ABUSE ASSESSMENT

I	II	III	IV	V	VI	VII	VIII
CK SOC	CIRCLE SUBSTANCES EVER USED	AGE AT FIRST USE	FREQ PAST 3 MONTHS	AMOUNT USED	USED IN PAST MONTH	USED IN PAST 24 HOURS	OVER DOSE
	Alcohol (beer, wine, liquor, etc.)						
	Marijuana, Hashish						
	Amphetamine (Crank, speed, Prescription diet pills, Crystal Meth)						
	Tranquilizers (Valium, Librium, Xanax, etc., - Benzodiazipenes)						
	Designer Drugs (Ecstasy, K)						
	Hallucinogens (LSD, Acid, mescaline)						
	Cocaine						
	Crack Cocaine						
	Heroin						
	Other Opiates (Morphine, Vicodin, OxyContin, Percodan, Codeine, etc)						
	Non Prescription Over-the-counter						
	Caffenated Beverages (coffee, colas, tea)						
	Tobacco (cigarettes, cigars, chewing)						

☐ Based on Assessment No S.A. Problem Indicated

Client Name:_____

Is client currently intoxicated? ☐ Yes ☐ No Any history of withdrawal? ☐ Yes ☐ No Any withdrawal symptoms present? ☐ Yes ☐ No

Last Substance(s) used: _____

Date of last use: _____

☐ Using	☐ Blackouts	☐ Loss of Control
☐ Family/Job Problems	☐ Obsessive Thinking about Substances	☐ Increased Tolerance
☐ Increased Level and Frequency of use	☐ Previous Withdrawal Symptoms	☐ Inability to Stay Free of Substance for twelve-week period
☐ Repeated efforts to control or reduce usage	☐ Making excuses for usage	☐ Sneaking
☐ Legal Problem	☐ Pregnant	☐ IV user
☐ Parents at risk of losing children	☐ Other_____	

ASAM PPC-2R

☐ Level 0.5, early intervention ☐ Level I, Outpatient Treatment ☐ Level II, Intensive Outpatient/Partial Hospitalization ☐ Level III Residential/Inpatient Treatment
☐ Level IV Medically-Managed Intensive Inpatient Treatment

XII. MENTAL STATUS: (Check all that apply and complete last sections)

Mood/Affect	☐ Normal	☐ Indifferent	☐ Angry	☐ Depressed
	☐ Anxious	☐ Labile	☐ Flat	☐ Elevated
	☐ Other:_____			
Object Relations:	☐ Dependent	☐ Distant	☐ Limited	☐ Appropriate
	☐ Mistrustful	☐ Other: _____		
Orientation:	☐ Normal			
	☐ Disoriented as to:	☐ Person	☐ Place	☐ Time
Memory:	☐ Good	☐ Fair	☐ Poor	
Judgment	☐ Good	☐ Fair	☐ Poor	
Attention/Concentration:	☐ Good	☐ Fair	☐ Poor	
Thought Content:	☐ Good	☐ Assaultive	☐ Phobias	☐ Suspiciousness
	☐ Antisocial Attitudes	☐ Obsessions/Compulsions	☐ Feels Persecuted	☐ Somatic
	☐ Complaints	☐ Feelings of Unreality	☐ Religiosity	☐ Guilt
	☐ Hopelessness	☐ Worthlessness	☐ Sexual Preoccupation	☐ Blames Others
	☐ Other _____			
Speech /Thought Process:	☐ Logical	☐ Blocked	☐ Indecisive	☐ Relevant
	☐ Flight of Ideas	☐ Other:_____		
Insight:	☐ Good	☐ Fair	☐ Poor	
Impulse Control:	☐ Good	☐ Fair	☐ Poor	
Physical Appearance:	☐ Neat	☐ Disheveled	☐ Body Odor	☐ Unremarkable

Suicide/Homicide Assessment

1. Client has suicidal/homicidal thoughts ☐ Yes ☐ No
2. Client has suicidal/homicidal urges ☐ Yes ☐ No

Client Name : _____

3. Client has suicidal/homicidal plans ☐ Yes ☐ No

4. Client has recently made a suicidal/homicidal attempt or gesture ☐ Yes ☐ No

5. Client has a history of suicidal/homicidal ideation ☐ Yes ☐ No

6. Client has made suicidal/homicidal attempts or gestures in the past ☐ Yes ☐ No

If yes, to any of the suicide/homicide questions assess the following: seriousness of intent, your thinking regarding duty to protect and warn, actions taken/recommendations made (e.g. call and warn significant others and/or victims, hospitalize, second opinion, refer for psychiatric evaluation, increased intensity of service, others as appropriate).

_____

_____

_____

XIII. CLIENT WELL BEING SCALE:

How do you feel about your life as a whole?

1	2	3	4	5	6	7	8	9	10
Terrible									Delightful

What would it take to get to a 10 (or move up the scale towards 10)? _____

XIV. INTERPRETIVE SUMMARY (Themes, Patterns and Treatment Considerations) Include client strengths, needs, abilities and preferences:

DSM-V-TR

Axis I Clinical Syndrome _____

Axis II Personality Disorder _____

Axis III General Medical _____

Axis IV Psychosocial and Environmental Problems _____

Client Name : _____

Axis V. Global Assessment of Functioning (1-90) Current GAF Score: _____ Past Year GAF Score: _____

Is client appropriate for treatment? Yes ☐ No ☐ If not, explain: _____

Treatment Modality: ☐ Individual ☐ Conjoint ☐ Family ☐ Group ☐ Didactic ☐ Intensive S.A.
☐ Other _____

Frequency: _____

Adjunctive Services:
Psychiatric Evaluation: ☐ Yes ☐ No

Do you have a need for assistive technology? Yes No

Would you like to complete an advanced directive? Yes No

TRAUMA SECTION

Do you have nightmares related to trauma? Yes No

Do you have flashbacks of traumatic event(s)? Yes No

Do you find yourself in dissociative states? Yes No

Do you have avoidance of or efforts to avoid distressing memories, thoughts, and/or feelings about or closely associated with the traumatic events? Yes No

Do you have avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about the traumatic event? Yes No

Do you have an inability to remember aspects of the traumatic events? Yes No

Do you have or feel fear, horror, guilt, or shame? (Circle the ones pertaining to you) Yes No

Do you have diminished interest or participation in significant activities? Yes No

Do you have feelings of detachment or

Client Name : _____

estrangement from others? Yes No

Do you have a hard time experiencing positive emotions? Yes No

Do you have irritable behavior and angry outbursts? Yes No

Do you have reckless or self-destructive behavior? Yes No

Are you hyper-vigilant? Yes No

Do you have an exaggerated startle response? Yes No

Do you have problems concentrating? Yes No

Have you witnessed trauma? Yes No

Have you witnessed physical abuse, neglect, violence or sexual assault (Please circle) Yes No

Physical Exam and Evaluation: ☐ Yes ☐ No

Support Groups (AA, NA, etc.) ☐ Yes ☐ No Other: _____

_____ _____

Signature of staff member completing intake Date

Appropriate for admission: ( ) Yes ( ) No

Recommendation: _____

_____

_____

_____

Signature Date

Client Name : _____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you (client) give permission to the clinical staff at Serenity Trauma Healing Center to provide psychotherapy treatment. This includes but not limited to all clinical and administrative staff of Serenity Trauma Healing Center. You have a right to terminate the therapeutic relationship at any time without fault.

Serenity Trauma Healing Center Organization

The clinical staff at Serenity work as a treatment team and consult together regarding cases and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

Limits of Confidentiality

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party outside of Serenity Trauma Healing Center. There are certain exceptions to this:

- When there is a reasonable suspicion of a child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client is likely to harm/himself unless protective measures are taken.
- If a client admits prenatal exposure to controlled substances that are potentially harmful.
- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients.

Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our session and any legal proceedings in which you are involved or expect to be involved, please let your therapist know.

Contacting Therapist

For life-threatening emergency, call 911, for other times, you may call your therapist during business hours or you may e-mail your therapist at any time.

Appointments

Sessions are 50 minutes in length (unless scheduled for longer sessions) and begin at the scheduled appointment time. If you arrive late, your session will be shorter. If you must cancel your session, please let your therapist know at least 48 hours in advance. You will be responsible for the full fee of any session canceled with less then 48 hours notice. For treatment to be effective, Clients must not be under the influence of intoxicating substances. If your therapist feels it necessary, you may be asked to reschedule your appointment for another time; this will be considered a late cancellation. In case you seek any type of treatment outside of Serenity Trauma Healing Center while you are seeing a practitioner in our center, please advise your therapist about such treatment.

I, _____, authorize Serenity Trauma Healing Center to charge the appropriate fee for the missed sessions.

Client Name : _____

Fee Billing & Payments

All services are billed at the standard rate. Weekly psychotherapy clients pay for services at the beginning of each session. Payment is due at the beginning of each treatment program or individual session. We accept payments by cash, check or credit card. If you signed up for one of our **longer treatment packages**, payment is due at least 24 hours in advance. There is **no refund** once the payment has been made for the 2-week-program. All payments for services are to be made directly to Serenity Trauma Healing Center, never to the name of the individual therapist.

If document preparation is required (e.g. legal proceedings, insurance appeals) clinicians reserve the right to bill for services at 100% of full per session fees. Serenity Trauma Healing Center is not an in network provider with any insurance, however statements can be provided for you to submit for insurance reimbursement or you can use Medivance, our third-party billing service. Medivance charges 6% for all reimbursement fees collected. Serenity Trauma Healing Center bills at current insurance rates to cover the complete cost of therapy services provided. Any balance due for your out-of-pocket fees are reimbursed to you after Serenity Trauma Healing Center receives the complete cost of therapy services billed to your insurance provider and the 6% fee is paid to Medivance on the total fees collected. In the event payment is not made when due, an additional 4% fee may be applied to the credit/debit card on file if no other payment arrangements have been made. If you commit to group therapy, the weekly fee for the group sessions is due even if you do not attend.

Credit Card Number_____

Expiration Date: _____CVV code: _____ Billing Zip Code: _____

Signature: _____