CLIENT INTAKE FORM

Please answer the following questions to the best of your ability. These questions are intended to help the therapist with the therapy process. All information is completely confidential.

Personal Information

Name: _____
(First) (Middle) Last)

Date of Birth: _____/_____/_____ Age: _____

Gender: Male ___ Female ___ Transgender ___ Other _____

Martial Status: Never Married ___ Partnered ___ Married ___

Separated ___ Divorced ___ Widowed ___

Number of Children: ___ Ages: _____

Current Address: _____

_____

May we send mail to your home address from this office? Yes ___ No ___

Home Phone: _____ May we leave a message? Yes ___ No ___

Cell Phone: _____ May we leave a message? Yes ___ No ___

Email : _____ May we send you an email? Yes ___ No ___

NOTE: Email may not be confidential

Emergency Contact: Person (Name) _____

Relationship: _____ Phone: _____

Referred by: _____

Are you currently seeing anyone for psychological services, professional counseling, psychiatric services, or any other mental health services Yes ___ No ___

Reason for Change: _____

Have you had any mental health services in the past? Yes ___ No ___
Reason for Change: _____

Are you currently taking any psychiatric medications? Yes ___ No ___
If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? Yes ___ No ___
If yes, please list:

_____

_____

General Health & Mental Health Information

How is your physical health at the present time?
Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___

List any persistent physical symptoms or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.

_____

_____

Are you taking any medications for physical/medical issues? Yes ___ No ___
If yes, please list:

_____

_____

Are you having any problems with your sleep habits? Yes ___ No___

If yes, check all that applies: Sleep too much ___ Sleep too little ___

Poor quality ___ Disturbing Dreams ___ Other _____

How many times per week do you exercise? _____ Days _____ Minutes/Hour

Are there any changes or difficulties with your eating habit? Yes ___ No___
If yes: Eating less ___ Eating more ___ Binging ___ Restricting ___

Have you experienced a weight change in the last two months? Yes ___ No___

Do you consume alcohol regular? Yes ___ No___
In a month, how many times do you have 4 or more drinks in a 24-hours? _____

How often do you engage in recreational drug use?
Daily ___ Weekly ___ Monthly ___ Rarely ___ Never ___

Do you currently or have you ever used tobacco in any form; e.g.: cigarettes, cigars, chew, vape, etc.? Yes ___ No ___

Have you felt depressed recently? Yes ___ No ___ If yes, for how long? _____

Have you had any suicidal thoughts recently? Yes ___ No ___
If yes: Frequently ___ Sometimes ___ Rarely ___

Have you had suicidal thoughts in your past? Yes ___ No ___
If yes, how long ago? _____ How often? Frequently ___ Sometimes ___ Rarely ___

Are you currently in a romantic relationship? Yes ___ No ___
If yes, how long have you been in this relationship? _____

Do you feel safe in your home? Yes ___ No ___

Do you have a history of or are you currently experiencing any form of domestic abuse? Yes ___ No ___

On a scale from 1 to 10, how would you rate the quality of your relationship (10 being great)? _____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.) Yes ___ No ___

_____

_____

Quick Check

Please check all of the symptoms you have experienced:

___ Extreme depressed mood
___ Mood swings
___ Rapid speech
___ Extreme anxiety
___ Panic attacks
___ Phobias
___ Disturbed sleep
___ Hallucinations
___ Memory lapse
___ Alcohol / Substance abuse
___ Body complaints
___ Eating disorder
___ Repetitive thoughts
___ Anxiety
___ Time loss
___ Repetitive behaviors
___ Homicidal thoughts
___ Suicide attempts
___ Trouble planning
___ Relationship trouble

Occupational Information

Are you currently employed? Yes ___ No___
If yes, who's your employer? _____

What is your position? _____

Are you happy in your current position? Yes ___ No___

Are you fulfilled in your current position? Yes ___ No___

Does your work make you stressed? Yes ___ No___

If yes, what are your work-related stressors? _____

_____

_____

_____

Religious /Spiritual Information

Do you practice a religion? Yes ___ No___

If so, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes ___ No___

What gives meaning to your life? _____

_____

Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

Issue		Family Member
Depression	Yes ___ No___	_____
Anxiety Disorder	Yes ___ No___	_____
Bipolar Disorder	Yes ___ No___	_____
Panic Attacks	Yes ___ No___	_____
Alcohol / Substance Abuse	Yes ___ No___	_____
Eating Disorder	Yes ___ No___	_____
Learning Disability	Yes ___ No___	_____
Trauma History	Yes ___ No___	_____
Domestic Violence	Yes ___ No___	_____
Obesity	Yes ___ No___	_____
Obsessive Compulsive Behavior	Yes ___ No___	_____
Schizophrenia	Yes ___ No___	_____

Other Information

List your strengths _____

_____

List areas you feel you need to develop _____

_____

_____

What do you like most about yourself _____

_____

What are some ways you cope with obstacles and stress? _____

_____

_____

What brought you to therapy today? What would you like to accomplish?

_____

_____

_____

Informed Consent

I authorize Renee C. Gillombardo, LMFT, PA to provide me with psychological services. I make this request freely and without coercion, I understand the risks and benefits of treatment and that experiencing thoughts or feelings that have been unexpressed may produce an emotional response that may be uncomfortable and may impact my relationships. I understand that I have the right to terminate treatment at anytime. It is our preference that you discuss your desire to terminate in advance so there en be proper closure and appropriate referral provided when necessary. The therapist may be ethically bound to terminate therapy if it is reasonably clear that the patient is not benefiting from therapy. I further understand that Renee C. Gillombardo, LMFT, PA and representatives cannot guarantee confidentiality of your **Protected Health Information** in the event you choose to use electronic transmission of any type, including but not limited to e-mail, text, social media Skype site to transmit **Protected Health Information**. _____ (initial)

Additionally, audio or video tapping of the sessions is not allowed. Audio or video tapping of a session will result in termination of the therapeutic relationship. _____ (initial)

I agree to turn off cell phone during session _____ (initial)

I understand that this office will not return calls to confirm appointments. _____ (initial)

Informed Consent continued

I understand my right of confidentiality is protected by Federal and State regulations. I further understand that my therapist is required or allowed by law to breach confidentiality in the following situations

- A danger to self or an identified person or their property
- Unable to care for self and your life is in danger
- Suspicion of abuse/neglect/endangerment of a child or observation or information of abuse of an elder
- Receipt by this office of a court order requesting release of your records, your arrest or an order to testify in a court proceeding.

Counseling and psychotherapy is a joint effort between patient and therapist. The patient is often required to express and experience painful and challenging beliefs and behaviors that are the essence of the difficulties in their life. We believe that the patient is the "change agent" and a strong commitment is necessary for lasting changes. We will provide the safe environment, clinical skill and expertise to help you navigate through the changes you wish to make. If you have any questions concerning this informed consent, lease ask your provider.

Patient Signature _____

Print Name _____ Date: _____

Informed Consent continued

Financial Policy Agreement

My insurance policy is a contract between my insurance company and me. I understand Renee C. Gillombardo, LMFT, PA will submit bills to my insurance company. I am responsible for any co-payments, deductibles, or amounts, which my insurance company does not pay to Renee C. Gillombardo, LMFT, PA _____ (initial)

Payment for services are due the day service is rendered. AII insurance co-payments are due the day services are rendered. This office does not bill for services rendered. _____ (initial)

We accept checks and cash payments. This office is a primary provider for Cigna Behavioral Health Care, United Health Care, and Blue Cross Blue Shield. If you wish to use another PPO insurance plan, we will provide the information you will need to submit to your insurance provider to receive partial reimbursement for services based on your specific insurance coverage. _____ (initial)

Since a 24-hour notice is required for cancellation, no show or reschedule of an appointment, you will be charged the full fee for services not cancelled within 24-hours, or if you do not show for an appointment if your appointment is on a Monday and you wish to cancel or reschedule your appointment, you must notify the office via voicemail the Friday before your appointment before 3:00 pm. _____ (initial)

Informed Consent continued

Checks returned for insufficient funds are subject to prosecution under the laws of the State of Florida. You will be charged a $35.00 service charge on any returned checks. Please note that this office does not refer delinquent accounts to a collection agency when satisfactory arrangements cannot be made. _____ (initial)

Important Notice: You have been advised that my office has an off-site insurance billing associate. This person is HIPAA compliant and does meet HIPPA regulations to protect your PHI. An encrypted email service is used to transmit billing information from my office to the associate. Only information necessary to bill your insurance is provided to the associate and he has no access to your clinical files. The encrypted service is Hushmail and they are a HIPPA compliant company. Please initial your achowledgement. _____ (initial)

We hope this policy statement will be helpful to you in understanding your financial obligations to this office. Your signature below acknowledges your acceptance of this financial agreement.

Patient Signature _____

Cigna, United Health Care, and Blue Cross Blue Shield patients only:

Insurance Subscriber's Name _____

Insured Date of Birth: _____ SS# _____

Informed Consent continued

Acknowledgement of Receipt of HIPPA Privacy Notice

Renee Gillombardo, LMFT has explained A.) the ways that my identifying information is protected, B.) the times when information about me may be released with specific permission, C.) my rights related to my medical information, and D.) The HIPPA privacy documents and the COVID informed consent for virtual and in person sessions are located on her website at reneegillombardo.com, see navigation tab, Patient Information. These documents contain information regarding my PHI (protected health information) and rights and responsibilities concerning COVID.

Your signature acknowledges your acceptance and understanding of this information.

Patient Signature _____

Date _____

Witness Signature _____

Date _____

THIS ACKNOWLEDGEMENT WILL BE RETAINED IN YOUR CLINICAL RECORD