PATHWAYS
COUNSELING CENTER

13105 W Bluemound Rd, Suite 100
Brookfield, WI 53005
P (262) 641-9790
F (262) 641-9791

INTAKE FORM – ADULT

INTAKE DATE:_____

CLIENT: LEGAL NAME_____ SS#:_____

PREFERRED NAME, if different:_____ BIRTH DATE:_____

CAREGIVER'S NAME:_____

ADDRESS:_____ CITY:_____STATE_____ZIP_____

PHONE: H (____)_____W (____)_____ CELL (____)_____

Is it okay to call the numbers above? ☐ YES ☐NO Is it okay to leave a voicemail? ☐ YES ☐NO

EMERGENCY CONTACT (Name and Phone):_____

RELATIONSHIP STATUS: ☐ Single ☐Married ☐Domestic-Partnership ☐Divorced

GENDER:_____

REFERRAL SOURCE: ☐ Another Professional ☐ Existing Patient ☐ Website/Online ☐Friend/Family

☐ Other:_____

PRIMARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME:_____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY NAME:_____ PHONE: _____

MEMBER ID#_____ GROUP#_____EFFECTIVE DATE: _____

CARD HOLDER'S EMPLOYER:_____

EXCLUSIONS: ☐ **90832 (30 min.)** ☐ **90834 (45 min.)** ☐ **90837 (60 min.)** ☐**90853 (Group)**

SECONDARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME:_____ BIRTH DATE: _____

INSURANCE COMPANY NAME:_____ PHONE: _____

MEMBER ID#_____ GROUP#_____EFFECTIVE DATE: _____

*****************PLEASE READ AND SIGN BELOW******************

INSURED/CLIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize **payment** of any medical benefits to Pathways Counseling Center. I also understand that I am responsible for my bill. I authorize **release** of any medical or other information necessary to process this claim. I permit a copy of these signatures to be used in place of the originals.

_____

SIGN DATE

Office Use Only: Diagnosis (ICD-10 CODE): _____ **THERAPIST:**_____

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Acknowledgment of Notice of Privacy Practices

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have been given an opportunity to read a copy of Pathways Counseling Center's Notice of Privacy Practices (laminated, two-sided Notice). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact David Bedrin or Lynn Dusold at Pathways Counseling Center, 13015 W. Bluemound Road, Suite 100, Brookfield, WI 53005.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member Date

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Consent for Transmission of Protected Health Information by Non-Secure Means

I, _____ AUTHORIZE _____
(Name of Client) (Name of Clinician)

TO USE THE FOLLOWING NON-SECURE MEDIA:

☐ Unsecured email
☐ SMS text message (i.e. traditional text messaging) or other type of "text message"
☐ Other media: Describe:_____

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

☐ Information related to the scheduling of meetings or other appointments
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ Other information Describe: _____

TERMINATION

☐ This authorization will terminate _____ days after the date listed below, OR
☐ This authorization will terminate when the following event occurs:_____

_____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
(Signature of Patient/Client) Date

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Consent for ADULT Admission For Mental Health Evaluation and/or Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Pathways Counseling Center. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment
2. A psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed will conduct the evaluation or treatment. Treatment will be conducted within th boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.
3. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
4. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I have received a fee schedule pertaining to my therapist.
5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential recor at Pathways Counseling Center, and I consent to disclosure for use by Pathways Counseling Center staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; o 3) if a court order is issued to obtain records.
6. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.
7. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
8. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Signature of client age 18 years or older or legal representative	**Date**
Signature of witness	**Date**

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Patient Bill of Rights

Please note the framed poster in the lobby regarding Patient Rights. Every patient at Pathways Counseling Center has the right to:

1. Be treated fairly regardless of race, national origin, sex, gender, age, religion, disability, or sexual orientation.
2. Receive prompt and adequate treatment.
3. Participate in their treatment planning.
4. Be informed of their treatment and care, including alternatives to and possible side effects of treatment.
5. Refuse treatment and medications unless court-ordered.
6. Be free from unnecessary or excessive medications.
7. Be treated with dignity and respect by all staff.
8. Be informed of their rights.
9. Be informed of any costs of their care.
10. Refuse drastic treatment measures.
11. Not to be filmed or taped without their consent.
12. File complaints about violations of their rights. If you feel your rights have been violated, you may:
    a. Discuss the matter with staff about any concerns. However, you do not have to do this before filing a formal complaint.
    b. If you want to file a written complaint, you may use the "Client Rights Grievance Form" available from the receptionist.
13. Be free from any retribution for filing complaints.

Rights regarding Record Privacy and Access:

1. Staff must keep patient information confidential.
2. Records cannot be released without patient consent with some exceptions.
3. Patients may see their records.
4. During treatment, access may be limited if the risks outweigh the benefits.
5. Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records.

_____ _____

Signature of client age 18 years or older or legal representative Date

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Adult Pre-Treatment Questionnaire

To better assess if we can meet your needs, please fill out as completely as you can and bring with you to your first therapy appointment. Use additional sheets of paper as needed. The information you provide is confidential and protected by law. We look forward to meeting you.

Date Completed:_____

Name: _____ Spouse/Partner's Name:_____

1. Gender: I identify as… Male ___ Female ___ Transgender ___ 2. Age: ____ Years

3. Ethnicity_____ 4. Religion_____

5. Partner/Marital Status: those
__ Never Married
__ Living together
__ Married
__ Separated
__ Divorced
__ Widowed

Please describe more about your current and past relationships and the quality of relationships:

_____

_____

_____

_____

6. Current Employment
__ Full-time
__ Part-time
__ Homemaker
__ Unemployed
__ Laid off
__ Student
__ Disabled
__ Retired

7. Education
__ Grade 8 or less
__ Some high school
__ High school graduate
__ Some college
__ College graduate
__ College beyond BS/BA

Please describe more about your current and past schooling/employment. Are you satisfied with your school/work?

_____

_____

8. Who lives in your home?

Name	Gender	Age (list)	Relationship?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current social supports: _____

_____

9. Are you currently under a physician's care? (circle one) Yes No Date of last physical exam _____

List **current medical conditions**, medications, dosage, and physician's name (Add on the back if needed):

Condition	Medication	Dosage	Physician

What kind of psychiatric meds have you taken in the **past**? What kind of response did you see?

_____

_____

Does your biological family have significant medical or psychiatric illnesses? (Include substance abuse, suicide, etc.)

_____

_____

What kind of sleeping pattern do you currently have (e.g. bedtime, wake time, restful, restless)?

_____

What kind of eating patterns or food issues do you currently identify as having?

_____

10. Have you received prior counseling or related services? (Circle one) Yes No (Add on the back if needed)

Name of therapist: _____ Where: _____

Length of treatment: _____mos./years How long ago? _____ mos./years ago

Problem(s) treated: _____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better\

Name of therapist: _____ Where: _____

Length of treatment: _____mos./years How long ago? _____ mos./years ago

Problem(s) treated: _____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: _____ Where: _____

Length of treatment: _____mos./years How long ago? _____ mos./years ago

Problem(s) treated: _____

Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

11. Do you have past or current experiences of abuse of any kind, including physical, emotional, verbal, or sexual? Please share below or with your therapist.

_____

_____

_____

_____

12. Please describe **current** substance use/abuse in the chart below. Please mark N/A if not applicable.

	Typical Frequency of Use In Past 6 Months					**Time of Last Use**		
	Daily	1-6 Times/ Week	Week end Use Only	Few Times A Month	Once a Month or Less	Within Past Week	Within Past Month	Over 1 Month Ago
Alcohol								
Marijuana								
Cocaine (Powder, Crack)								
Amphetamines (Crystal Meth)								
Sedatives								
Minor Tranquilizers (Valium)								
Hallucinogens								
Barbiturates								
Heroin								
Other Opiates/Narcotics								
Inhalants								
Nicotine (Cig, Vape)								
Caffeine								
Other: _____								

13. Please describe any current or past legal trouble (criminal and family) you are in or have had:

_____

_____

14. Please check up to 3 of the **most important** reasons listed below which led you to seek treatment:

__ Depression or anxiety
__ Worry about drinking or drug use
__ Communication problems
__ Desire to improve sexual relations
__ Parent/child conflict
__ Sexual orientation questions
__ Problematic or too much anger
__ Social isolation or other social challenges
__ Trouble controlling impulses
__ Abuse (physical/sexual/emotional/verbal)
__ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
__ Thinking of harming self or others
__ Learning/memory problems
__ Difficulty with loss or death
__ Want relationship to be better
__ Divorce counseling
__ Individual counseling
__ Pre-marital counseling
__ Family counseling
__ Couples counseling
__ Partner/family member wanted me to come
__ Gender identity/transition
__ Other: _____

15. Regarding the **most important** reason that brings you here, please rate the following:

Reason 1. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

Reason 2. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

Reason 3. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

16. Who referred you to Pathways Counseling Center? _____

17. What questions do you hope will be answered through therapy?

_____

_____

18. Please describe some of your personal strengths you possess:

_____

_____

19. Please describe some of your personal challenges or obstacles in your way:

_____

_____

20. How will you know that things are getting better?

_____

_____

21. Is there anything else you want the therapist or counselor to know before your first session?

_____

_____

22. To get a better understanding of your symptoms, please complete the table below and bring to your first therapy appointment.

Over the lasts 2 weeks, how often have you been bothered by the following symptoms?

	Never	Several days	More than half the days	Daily
Sadness, hopelessness, feeling down				
Poor appetite or overeating; weight loss or gain				
Loss of interest or pleasure in doing things				
Fatigue or loss of energy				
Feeling bad about yourself – that you are a failure or have let yourself or your family down				
Trouble concentrating, making simple decisions				
Thoughts of death or suicide				
Trouble falling or staying asleep, restless and unsatisfying sleep, or sleeping too much				
	Never	Several days	More than half the days	Daily
Restlessness, feeling keyed-up, or on edge				
Being easily tired				
Problems concentrating or mind goes blank				
Irritability				
Muscle tension				
Trouble falling or staying asleep, or restless and unsatisfying sleep				

ADULT PRE-TREATMENT QUESTIONNAIRE

	Never	Several days	More than half the days	Daily
An intense and persistent fear of a social situation in which people might judge you				
Fear that you will be humiliated by your actions				
Fear that people will notice that you are blushing, sweating, trembling, or showing other signs of anxiety				
Knowing that your fear is excessive or unreasonable				

Please provide any other information that you feel is important for the therapist to know:

_____

_____

_____

_____

Signature: _____ Date: _____