Autumn Leaf Counseling
5757 S. Madison Street
Hinsdale, IL 60521
630.228.6011

New Client Intake Form

Demographic Information

PLEASE PRINT

Client Name:	Age:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Mobile Phone:
Emergency Contact Person/Relationship:	
Emergency Contact Phone:	How did you hear about us?
Occupation/Year in School:	Marital Status:

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as client)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Client:	

Medical/Mental Health History

Please briefly describe why you are seeking therapy: ____

____

____

Any Previous Therapy/Counseling: ____

If yes, what type of therapy and how long did you attend? ______________________________

____

Was therapy beneficial to you? Why did you feel it helped/didn't help? ___________________

____

Are you currently in treatment with any other counselor or psychiatric provider? ______________

Medical Problems (describe):____

History of any hospitalizations (medical and/or psychiatric): ___________________________

____

Name of Primary Care Physician:________________________Phone:______________________

Is it okay for me to inform your Physician that you are in therapy? Yes_____ No______

Name of Psychiatrist (if applicable): __________________________ Phone: ______________________

Please list any current medications and their dosage(s)________________________________

Suicide Information	Check all that apply
None: No suicidal thoughts	I have never had thoughts of suicide
Mild: Some thoughts, no plan	I am experiencing these thoughts now I have experienced these thoughts in the past I have experienced these thoughts in the past Date:____________
Moderate: Some thoughts, vague plan, low levels of lethality	I am experiencing these thoughts now I have experienced these thoughts in the past I have experienced these thoughts in the past Date:____________
Severe: Significant thoughts, plan is specific, and there is a means to execute the plan	I am experiencing these thoughts now I have experienced these thoughts in the past I have experienced these thoughts in the past Date:____________

Have you ever actually attempted suicide at any time in your life? Yes / No

If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:

____

____

SYMPTOM CHECKLIST

Review the following symptoms and mark the symptoms you are experiencing.

PHYSICAL SYMPTOMS:

_____headaches	_____insomnia	_____excessive sweating
_____muscle aches	_____daytime drowsiness	_____increased appetite
_____stomach aches	_____diarrhea/constipation	_____poor appetite
other:__________________________________		

BEHAVIORAL SYMPTOMS:

______increased cigarette use	______cutting	______ low motivation/energy
______increased alcohol use	______skin picking	______excessive energy
______increased illegal substance use	______binge eating	______poor self care

other:___________________________________

EMOTIONAL SYMPTOMS:

______easily frustrated	______cry easily	_______changing moods
______anger	______worries	_______thoughts of suicide
______excessive spending	______impulsive risk taking	_______excessive exercise
______feel something bad will happen	______ hopeless	_______thoughts of homicide
______restricting food intake	______avoiding social contacts	_______hair pulling
______intrusive/upsetting thoughts	______racing thoughts	_______irritable
______poor concentration	______forgetfulness	_______purging
______scared	______lonely	_______sadness

other:___________________________________

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Our conversations and our notes are not shared with anyone without your written permission, with these exceptions:

1. Diagnosis and dates of service shared with your insurance company to process your claims.
2. Information you tell us about physical, sexual or elder abuse; then, by Illinois state law, we will report this to the appropriate welfare agency.
3. When you sign a release of information to have specific information shared.
4. If you tell us you are in danger of harming yourself or others.
5. Information shared with our supervisor or consultant.
6. When required by law.

Please be informed, Autumn Leaf Counseling LLC is not able to provide emergency services in times of imminent crisis. If you are in need of emergency services, please contact your medical doctor, your psychiatrist, call 911 or go to your nearest emergency room. DuPage County offers crisis intervention services and can be reached at 630-627-1700. Please know you have the right to review and receive copies of your client file. This file can be sent to another mental health professional, treatment facility, school or medical doctor, only with your written consent.

I have read and understand the confidentiality policy and its limits and rights to records.

____________________________________ ____________________

Signature Date

____________________________________ ____________________

Signature of Parent/Guardian if client under age 18 Date

INFORMED CONSENT FOR TEXT (SMS) MESSAGING

Please check one option below:

_____ Yes, I agree to receive text messages from Autumn Leaf Counseling at the phone number listed above.

_____ No, I do not want to receive text messages from Autumn Leaf Counseling.

Voluntary Participation: Participation in our text (SMS) messaging service is entirely voluntary. You have the right to refuse or withdraw your consent at any time.

Benefits and Risks: Benefits: The text (SMS) messaging service aims to keep you informed about **Autumn Leaf Counseling** by providing an additional method of convenient and timely communication.

Risks: While every effort will be made to protect the security and confidentiality of information transmitted through text (SMS) messages, there are inherent risks associated with all electronic communication. These risks include unauthorized access, loss of privacy, and potential breach of sensitive information. It is important to be aware that text (SMS) messages may not be entirely secure and could be intercepted or accessed by unintended recipients.

Potential Costs: Participation in the text (SMS) messaging service may involve standard text messaging charges applied by your mobile service provider. Please consult your mobile service provider regarding any applicable fees or charges.

Payment and Fees

Payment is due at the time of service. You understand you are fully responsible for all fees for services during the treatment period. If you are using insurance, it is your responsibility to understand your benefits, coverage and limits of coverage. If authorized by you to do so, Autumn Leaf Counseling LLC, will submit claims to your insurance, but the final responsibility for payment is yours. Cash, check or credit cards are acceptable forms of payment for services.

Fees:
Initial assessment - $150
50-minute session - $140

No show or cancellation with less than 24 hours notice - $75

I have read and understand the payment policy and fee for late cancellation or missed without notification session.

______________________________________ ____________________
Signature Date

______________________________________ ____________________
Signature of Parent/Guardian if client under age 18 Date