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 last experienced this on: 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 last experienced this on: 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 last experienced this on: 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 ache	___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

EMOTIONAL SYMPTOMS:

___easily frustrated	___cry easily	___changing moods
___anger	___worried	___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	___sad 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

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