Serenity Coaching and Counseling , LLC

Group Intake

Welcome! Please fill out the form below. Information you provide is confidential, and will help you and your counselor/coach when you meet for the first time. Please feel free to ask questions. (**Use back of page if not enough space**).

Name _____ **Age** _____ **Date of Birth** _____/_____/_____

Address _____
Street City State Zip

Is it appropriate to send correspondence to this address? ☐ Yes ☐ No

Would you like mailings of our new groups or services? ☐ Yes ☐ No

Phone (primary) _____ Can we leave you messages? (please circle) ☐ Yes ☐ No

(Secondary Phone) _____ Contact **E-mail** _____

Would you like appointment reminders? If so, please circle: Text Email Text and Email Decline All

Do you agree with e-mail correspondence for scheduling purposes or for general questions? ☐ Yes ☐ No

Emergency Contact: _____
(name, relationship, phone number, address)

Primary Care: _____
(name, address, phone number)

What **Services** are you seeking: (circle) Group Only Individual Couples Family

Please summarize your specific **GOALS** and **EXPECTATIONS** for the group you will be attending:

_____

_____

_____

How did you hear about us? _____

Group Leader: _____ Date: _____

Client Name: _____ DOB: _____

Group Intake Questionnaire:

1. Please check the box which best describes your general happiness and well-being:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Very Poor — Excellent

2. Please check the box which best describes how well you are doing on your job:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Not Working | Cannot Function | Serious Problems | Moderate Problem | Mild Problems | No Problems

Level of Education: _____ Occupation: _____

3. Family Status (please circle): Single Married Separated Divorced Widowed Other_____

Who do you live with: _____ Children? Do they live with you? _____

Who are significant people in your life: _____

*Please check the box which best describes how well you are doing in your marital/significant other relationship:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Not Applicable | Cannot Function | Serious Problems | Moderate Problem | Mild Problems | No Problems

*Please check the box which best describes how well you are doing in your family relationships:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Not Applicable | Cannot Function | Serious Problems | Moderate Problem | Mild Problems | No Problems

*Please check the box which best describes how well you are doing in relationships with people outside your family:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Not Applicable | Cannot Function | Serious Problems | Moderate Problem | Mild Problems | No Problems

Any family history of mental health or substance abuse issues? Yes ☐ No ☐

If Yes, Please Describe: _____

4. Please check the box which best describes your current physical health:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐
Very Poor — Excellent

Do you have any medical or physical health issues that we would need to know about?

_____

Please List Medications: _____

Who prescribes them? _____
Would you like us to contact them? Yes ☐ No ☐

Client Name: _____ DOB: _____

5. Have you ever seen or are currently seeing a coach/counselor/therapist or been hospitalized for a mental health, emotional disorder, or a substance use disorder? If so, who/what, facility or hospital and when:

_____

_____

6. Have you ever experienced a trauma or traumatic event that we should know about? Yes ☐ No ☐

If comfortable, please let us know: _____

7. Do you have other supports we should know about? (self-help, psychiatry, groups, probation, etc):

_____

8. Please Circle:

Alcohol Use: Never 1-4 timer per month 2-3 per week Daily How Long: _____

Level of Consumption: 1-2 drinks per sitting 3-4 drinks per setting 5 drinks or more

Intoxication Frequency: Never 1-4 timer per month 2-3 per week Daily

Substance Abuse Assessment: None Marijuana Sedatives Stimulants Cocaine Opiates Hallucinogenic

Frequency: Never 1-4 timer per month 2-3 per week Daily

9. Do you have any current or past legal issues we should know about?_____

10. Is there anything about you (spirituality, cultural beliefs, identity, etc) that we should know about?

_____

11. Are you requesting any specific accommodations? If so, please describe:

_____

12. Is there anything else we should know about you?

_____

_____

_____

Group Leader Comments: _____

_____

Group Leader: _____Date: _____

Serenity Coaching and Counseling , LLC

(con't)

* During my intake, I have received the following information:

- ✓ Privacy Notice (HIPAA)
- ✓ Notification of clients' rights
- ✓ Agency policies and procedures
- ✓ Grievance Procedure
- ✓ Copy of the Orientation to Treatment and Client Policies Pamphlet

* I understand that it is my responsibility to attend all scheduled appointments. If I need to reschedule an appointment, I will call with at least eight (8) hours notice. I understand that there will be a $25.00 fee for any appointments that I do not attend and do not cancel (no shows). I understand that I am responsible for this fee.

* I understand that if I "no show" two appointments, or if I cancel two appointments within a 30 day period, my case will be closed.

_____ _____

Client Name (Please Print) Date of Birth

_____ _____

Client Signature Date

Consent to Release Information & Authorization of Benefits (Insurance)

Client: _____ DOB: _____ Are you the subscriber? (please circle) Yes No

If not subscriber, who is? _____ Subscriber DOB: _____

Subscriber Address/Phone #: Same as address listed or: _____

Insurance Company: _____Insurance ID#: _____ Copay: $_____

Masshealth MCO/MMIS#/Other information: _____

*I authorize the release of information as may be required by my insurance company, their reimbursing agency, or as may be otherwise necessary for payment of claims resulting from my mental health treatment. *I understand information will be disclosed for processing claims for treatment I have received, quality review and continuity of care purposes. This may include information contained in my records that concerns medical illness, mental illness or substance abuse, and/or domestic violence. *I authorize payment directly to Serenity Coaching and Counseling, LLC of benefit otherwise payable to me. *I understand that I am financially responsible for any deductible, co-insurance, non-covered charges, or charges resulting from my failure to follow my insurers' referral guidelines. *I understand that I may revoke release at any time, but I must notify Serenity Coaching and Counseling, LLC of revocation in writing.

Having read and understand the provisions, I consent to these statements and authorize Serenity Coaching and Counseling, LLC to act in accordance with these provisions.

_____ _____

Client Name (Please Print) Date of Birth

_____ _____

Client Signature Date

Witness: _____ _____ _____

Name (Please Print) Signature Date