Client Intake Form

Client Information			**Today's Date:**
Name			
Date of birth			
Address	Zip Code		
Cell number		Work Number	
Email Address		Okay to contact via email: circle one	Yes No
Referred by			
Emergency Contact Name		Emergency Contact Phone Number	
Do you give permission to contact person above in an emergency?			
Primary Care Doctor			
Current Medications			

If you are using insurance please complete bottom portion:

Insurance ID#	
Insurance Group #	
Subscriber Name	
Subscriber's Social Security Number	
Subscriber's Date of Birth	
Subscriber Address	
Subscriber Phone #	
Name of subscriber's employer	
Insurance Plan name	

Employment	
Current Employer	
Position	
List any work issues	

Substance Use/Abuse			
Have you used any of the following substances?	Date of last use	Frequency of use	Other information
Alcohol Y / N			
Marijuana Y / N			
Hashish Y / N			
Cocaine / Crack Y / N			
Narcotics / Heroin Y / N			
Hallucinogens / PCP LSD Y / N			
Amphetamines / Speed Y / N			
Barbiturates/Tranquilizers Y / N			
Inhalants Y / N			
Diet Pills Y / N			

History of treatment			
Have you received counseling in the past?	Yes / No	Number of times?	
Have you participated in substance abuse treatment in the past?	Yes / No	Number of times?	

Reason for seeking counseling	
Description of reason for seeking counseling	

40 Question Survey

INSTRUCTIONS: READ EACH ITEM BELOW CAREFULLY AND DECIDE *HOW MUCH* YOU HAVE EXPERIENCED EACH SYMPTOM *IN THE LAST MONTH. CIRCLE* THE APPROPRIATE RESPONSE.

0= Not at all 1= A little bit 2= Moderately 3= Quite a bit 4= Extremely

1. Headache	**0**	**1**	**2**	**3**	**4**
2. Nervousness or shakiness inside	0	1	2	3	4
3. Feeling critical of others	**0**	**1**	**2**	**3**	**4**
4. Trouble remembering things at work	0	1	2	3	4
5. Feeling easily annoyed or irritated	**0**	**1**	**2**	**3**	**4**
6. Feeling low in energy or slowed down	0	1	2	3	4
7. Feeling that most people can not be trusted	**0**	**1**	**2**	**3**	**4**
8. Poor appetite	0	1	2	3	4
9. Crying easily	**0**	**1**	**2**	**3**	**4**
10. Temper outbursts that you could not control	0	1	2	3	4
11. Blaming yourself for things	**0**	**1**	**2**	**3**	**4**
12. Feeling blocked in getting things done	0	1	2	3	4
13. Feeling lonely	**0**	**1**	**2**	**3**	**4**
14. Worrying too much about things	0	1	2	3	4
15. Feeling no interest in things	**0**	**1**	**2**	**3**	**4**
16. Feeling fearful	0	1	2	3	4
17. Your feelings being easily hurt	**0**	**1**	**2**	**3**	**4**
18. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
19. Feeling that people are unfriendly or dislike you	**0**	**1**	**2**	**3**	**4**
20. Heart pounding or racing	0	1	2	3	4
21. Feeling inferior to others	**0**	**1**	**2**	**3**	**4**
22. Drinking more alcohol than usual	0	1	2	3	4
23. Trouble falling asleep	**0**	**1**	**2**	**3**	**4**
24. Having to check and double-check what you do	0	1	2	3	4
25. Difficulty making decisions	**0**	**1**	**2**	**3**	**4**
26. Your mind going blank	0	1	2	3	4
27. Trouble concentrating at work	**0**	**1**	**2**	**3**	**4**
28. Overeating	0	1	2	3	4
29. Sleep that is restless or disturbed	**0**	**1**	**2**	**3**	**4**
30. Difficulty getting the job done	0	1	2	3	4
31. Having urges to break or smash things	**0**	**1**	**2**	**3**	**4**
32. Feeling very self-conscious with others	0	1	2	3	4
33. Others not giving you proper credit for your achievements	**0**	**1**	**2**	**3**	**4**
34. Shouting or throwing things	0	1	2	3	4
35. Feeling pushed to get things done	**0**	**1**	**2**	**3**	**4**
36. Thoughts of ending your life	0	1	2	3	4
37. Never feeling close to other persons	**0**	**1**	**2**	**3**	**4**
38. Feelings of guilt	0	1	2	3	4
39. Needing a medication or using drugs more	**0**	**1**	**2**	**3**	**4**
40. Having problems with co-workers	0	1	2	3	4

Informed Consent to Treatment

The purpose of this form is to acknowledge voluntary consent to treatment by the clinician assigned to you by St. Louis Counseling & Wellness listed below. By signing this form you are agreeing with the following:
I acknowledge that I am voluntarily receiving service from _____.
I understand that I can discontinue services at any time. (therapist's name)
I understand that information shared with the named clinician will be held in the strictest of confidence. I give my permission for the following disclosures of information:

- CLINICAL SUPERVISION: To ensure quality of care, I understand that my information may be discussed with a clinical supervisor to assist in clinical development with the intent to improve clinical services.
- AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I authorize St. Louis Counseling & Wellness to release all necessary information to any insurance company, employee assistance program, health plan or other entity (third party payor) which may be responsible for paying for my care. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to St. Louis Counseling & Wellness and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
- PAYMENT FOR SERVICES: In return for services to be provided by St. Louis Counseling & Wellness, I promise to pay for services rendered by St. Louis Counseling & Wellness to me or for my benefit. If the services I receive from St. Louis Counseling & Wellness are covered by a third party payor (EAP, insurance, etc.), St. Louis Counseling & Wellness may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

I understand that my information may not be released without my written consent with the following exceptions:

- I present a danger to myself or someone else
- Actual or suspected child abuse or neglect. (Clinician named above is a mandated reporter.)
- Valid court order requesting records
- Appropriate discussion of case with other professionals for consultation or supervision

I agree to pay an appointment fee of $60 if I fail to give 24 hour notice to cancel an appointment.
_____ (initial here)

I acknowledge that I have received a copy of "Notice of Privacy Practices" with this Informed Consent to Treatment. I may revoke this consent in writing at any time.

_____	_____	_____
Client's Printed Name	Client's Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date

Attachment B

E⁴ Health, INC
Statement of Understanding

Welcome

E⁴ Health, INC (E⁴ HEALTH, INC) offers assessment, short-term counseling, and referral services to the employees of our client organizations and their eligible family members. Services provided within the EAP counseling benefit are provided at no direct cost to the employee or family member. It is the responsibility of the client to pay for any services outside of the EAP counseling benefit.

Client Rights

Information that you provide to E⁴ HEALTH, INC Health will not be released without your prior knowledge and written consent except under the following circumstances: E⁴ HEALTH, INC Health counselors may be required to and will report threats of imminent physical violence or of suicidal intent as well as suspicion of child/elder abuse or neglect. Furthermore, your E⁴ HEALTH, INC Health counselor may consult or share clinical information with other E⁴ HEALTH, INC Health counselors or their contracted mental health professionals when necessary to provide you with quality clinical services.

Upon request, you are entitled to information about the methods of counseling, the techniques used, the duration of counseling, information regarding educational degrees, clinical training and experience, licenses and credentials of your counselor. When requested in writing, a treatment summary can be provided at your expense. You may terminate counseling at any time. In a professional counseling relationship, sexual intimacy is never appropriate and should be reported to your Regulatory Agency. Contact information for the Regulatory Agencies is available from our call center. Any time you have questions or comments about E⁴ HEALTH, INC Health services, please call 1-800-227-2195 (if in the U.S. or Canada), or via confidential fax at 401-274-6472

If you wish to file a complaint about E⁴ HEALTH, INC Health, you may do so by telephone at 1-800-227-2195, by fax at 401-274-6472. If you speak a language other than English or Spanish, or require assistance due to a visual or hearing problem, your counselor will contact E⁴ HEALTH, INC Health to assist you with the Grievance Procedure. If you need an interpreter to assist in filing a complaint, one will be provided, and will contact you to obtain the information about your grievance.

Client Responsibilities

You must cancel 24 hours in advance when you are unable to keep an appointment, or the missed session will "count" toward your EAP counseling benefit for that year.

It is E⁴ HEALTH, INC Health's policy not to participate in clients' legal actions such as custody suits, divorce proceedings, personal injury suits, etc. If you are considering or are involved in such actions, your E⁴ HEALTH, INC Health counselor can refer you to a mental health professional that is experienced in legal matters. Because such services are beyond your EAP benefit, costs for these services will be your responsibility.

I understand that E⁴ HEALTH, INC Health may review my clinician's file regarding my treatment or my dependent's treatment as part of E⁴ HEALTH, INC Health's Quality Assurance Program. I understand that my records may be transferred electronically. I understand that my participation in EAP counseling is voluntary and that all my records are protected by confidentiality regulations. I have read this form and understand my rights and responsibilities as a client of E⁴ HEALTH, INC Health. I hereby give my permission to have E⁴ HEALTH, INC Health follow-up with me upon completion of treatment to make sure that I am satisfied with the services rendered.

Please keep in member file, do not return this Statement of Understanding to E⁴ HEALTH, INC.

_____	_____	_____
Client's Signature (Parent if client is minor)	Client's PRINTED NAME	Date