Breaking Free, LLC
COUNSELING SERVICES

Welcome to Breaking Free, LLC Counseling. Thank you for selecting our facility for your mental health needs. Our mission is to provide a compassionate experience to help individuals get through the struggles and obstacles they come across throughout life.

Any discussions with our therapists are confidential and are protected by HIPPA (Health Insurance Portability & Accountability act). We do not release any information without written consent by our clients, unless mandated by law.

Please complete all forms in this packet and bring to your first appointment. Unfortunately, if paperwork is incomplete, we will have to reschedule your appointment.

If you need to cancel or reschedule your appointments, we ask for you to give us a 24-hour notice in advance or before 4PM the day prior of your appointment, so we can provide care to other individuals who are waiting.

In case of an emergency, please go to your nearest emergency room or call the crisis hotline at: 800-560-5535

We look forward to meeting with you and providing the highest quality of care!

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PATIENT INFORMATION

NAME _____ **M F** **Birthday** / /

Address _____

Home# - - **Cell#:** - - **SS#** - -

Parents name: (for minors only) _____

Employer: _____ **Work#** - -

Emergency Contact/Relation: _____ **Phone** - -

Primary Care Doctor: _____

INSURANCE INFORMATION

You are required to provide accurate information, or you could be responsible for 100% of billings, if you have a secondary insurance then it must be coordinated with your primary. You are responsible to inform Breaking Free LLC of any changes in insurance.

Primary Insurance: _____ ID# _____

Group# _____ Subscriber: _____

Address: _____ DOB: / /

Secondary: _____ ID# _____

Group# _____ Subscriber: _____

Address: _____ DOB: / /

EMPLOYEE ASSISTANT PROGRAM (EAP)

Name of program: _____ Auth# _____

Our services are billed to your insurance as a courtesy, provided all information is given to us at time of service. Any outstanding accounts (more than 90 days) will be sent to collections unless an agreement has been made for payment arrangements with the Office Manager. Any No Shows/Late Cancellations will be billed to the responsible party and are not covered by insurance. See no show/late cancellation policy. Payments are due on the 15th of the month. Late payments could incur a monthly 2% charge.

Print name of responsible Party**:** _____

Signature: _____ **Date** / /

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No Show-Late Cancellation Policy

Our provider's time is very valuable, and it is the sole responsibility of the client or representative to call 24 hours in advance to reschedule or cancel appointments.

If we do not hear from you regarding your scheduled appointment and you do not call our office to cancel or reschedule with advanced 24-hour time frame, you could be charged up to $155.00. **This charge is not billable to your insurance.**

We have a confidential voicemail that is time stamped, so if you need to make changes regarding your appointment, please leave a message with your name, time of your appointment and the reason you are cancelling.

If you are billed for a late cancellation or no-show appointment and you fail to pay or make payment arrangements, this could impact the ability to receive services you require from your counselor.

Any client failing to cancel their appointment in a timely manner, or no show more than two appointments may receive a discontinuation of services letter due to the lack of participation in your treatment.

You deserve quality care, so we would like to take this opportunity to thank you for choosing Breaking Free, LLC counseling services.

Print Name: _____

Signature: _____

DATE: _____/_____/_____

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Release of Information

This is NOT a records release

If you wish to have anyone act on your behalf as far as scheduling, billing or verbal communication with your Counselor or office staff, please indicate below their name and relationship to you and what they are authorized for. If you choose not to have anyone act on your behalf, please write "no one" in the space provided below. Any client 14 years or older shall sign this form, clients 13 and under must be signed by legal guardian.

Name & Relationships to Client:

_____

_____

_____

_____

I also understand that I may revoke this release **in writing** at any time, except for action already taken. By signing and dating this release, you accept this authorization for office staff and/or your counselor to communicate with others indicated above for 12 months or 90 days after the last face to face contact, whichever is later.

It is Breaking Free LLC's right and mandated responsibility to report at risk behavior for self-harm or the harm to others.

SIGN: (Client's 14 and up) _____

SIGN: (Legal guardian 13 and younger) _____

DATE:_____/_____/_____

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Privacy Policy

I authorize Breaking Free, LLC to disclose the health and clinical information only for treatment, payment, and health care operations. Breaking Free LLC is not liable for any internet security breaches for online counseling. Our Tele-Therapy uses a secure platform called Doxy.me however Breaking Free LLC is not liable for any internet breaches.

Health Care: Breaking Free, LLC may disclose necessary health information for administration and business purposes.

Payment: Breaking Free, LLC may disclose limited health and demographic information for obtaining eligibility and claim processing.

Treatment: Breaking Free, LLC may use your health care information to provide clinical services to other personnel that are involved in your treatment.

Assessments and progress notes are subject to the supervision review by Vicki North, Clinical Supervisor, at Breaking Free LLC. Some treatments by an intern, may be billed under the licensed clinician's name.

I understand that my health information is confidential and cannot be released for other than those listed above, without written my consent, unless mandated by law. I may revoke the consent at any time if I do so in writing, except to the extent Breaking Free, LLC has already used or disclosed on reliance of this signed consent.

Print Name of Client: _____

Clients Signature: (or person authorized by law to act on behalf of client)

Please Sign: _____

Date: ____/_____/_____

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Consent for Treatment

By signing this form, you voluntary agree to receive mental health services from Breaking Free, LLC, counseling for any such care, treatment and/or services that are considered advisable and necessary.

In the event that services are no longer needed, or my therapist is no longer practicing, I understand that my records will remain at Breaking Free LLC until I authorize in writing to deliver said records to any therapist or facility of my choice.

I understand and agree to participate in the planning of my treatment and may stop services and/or treatment at any time.

I acknowledge by signing this form that I have read and understand the terms contained herein.

I also consent that Breaking Free LLC may communicate with me by phone, email or mail.

Client name: (print)_____

Client/Parent/Guardian: (signature)_____

Date: ____/_____/_____

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Adult Intake Questionnaire

Completing this form allows the Therapist to spend more time with you to prepare and address your concerns for future appointments

Name: _____ **Assessment Date:** ___/____/_____

DOB: _____/_____/_____ **AGE:** _____ Male_____
Female_____

Status: Married___ Living as Married____ Single___ Divorced____ Widow/Widower____

Veteran: yes____ No____ If Yes, Branch of Service: _____

Strengths, Interests, Hobbies, and Abilities

_____
_____
_____
_____
_____

Reasons for Seeking Help

_____
_____
_____
_____
_____

Problem Areas

Job___ Relationship Issues___ Sexuality___ Financial___ Drug Use___ Alcohol Use___

Parenting/Family Issues___ Recovery Issues___ Recent Loss/Death___ Grief___ Anger___

Sleep___ Self Esteem___ Chronic Pain/Illness___ School-*grades, teachers, peers*___

Abuse Issues-*emotional, sexual, physical, verbal*___ Other traumatic events____

Eating Disorder (*anorexia, bulimia, compulsive eating, binge eating)* ____

Self-Control (*anger, sexual impulses, food, excessive spending)* ____

Emotions (*mood swings, feeling overwhelmed, hard to control emotions)* ____

Thinking (*disorganized or unwanted thoughts, memory loss, obsessive thoughts)* ____

Other (please explain) _____

Current Symptoms

Please check all that apply

Heart Racing___ Trembling___ Difficulty Breathing___ Diarrhea/Vomiting___ Cold Sweats___

Compulsive Behavior___ Excessive Worrying___ Panic Attacks___ Trembling___ Stress____

Fear of Leaving Home___ Family History of anxiety/panic attacks____ Obsessive Fears____

Obsessive Thoughts___ Sense of Hopelessness___ Low Energy___ Low Self Esteem____

Loss of Appetite___ Depressed/Unhappy___ Lack of Motivation___ Suicidal Thoughts____

Sleep Difficulty___ Memory Problems___ bipolar disorder___ History of Depression____

Auditory Hallucinations___ Visual Hallucinations___ Doing Things not Remembered Later____

Abnormal Body Sensations___ Feeling others plotting against you___ Hyperactivity___

Seizures___ Feeling of not needing sleep___ Suicide Attempts____(when)_____

Other Symptoms: _____

_____

Activities of Daily Living

(Please check all that you currently have difficulties with and **briefly describe the problem**)

- ◊ Bathing_____
- ◊ Grooming/Hygiene_____
- ◊ Feeding Self_____
- ◊ Dressing Self_____
- ◊ Mobility_____
- ◊ Housework_____
- ◊ Shopping_____
- ◊ Managing Money_____
- ◊ Taking Medication_____
- ◊ Other_____

Family of Origin History/Problems

Drug/Alcohol Problems____ Suicide____ Depression____ bipolar disorder____

PTSD____ Anger Issues____ Anxiety____ Personality Disorder____

Briefly tell me about the history of the issue that brings you to counseling today.

_____
_____
_____
_____
_____
_____

Please list previous mental health issues/treatment

_____
_____
_____
_____
_____

Medications

Please list all Mental Health Medication, dosage, and reason for medication

_____
_____
_____
_____
_____

Please list Physical Health Medication, dosage, and reason for medication.

_____
_____
_____

_____
_____
_____
_____

Developmental History

Did mother/father use drugs before your birth? No___ Yes___ explain_____

Developed at the same rate as other children? No___ Yes___ explain_____

Speech/Language Difficulty? (Hearing, speaking) No___ Yes___ explain_____

Visual Impairment? No___ Yes___ explain_____

Motor Skills Impairment? No___ Yes___ explain_____

Cognitive Impairment? No___ Yes___ explain_____

Deficit in Social Skills? No___ Yes___ explain_____

Social History

Who lives with you:

_____
_____
_____
_____

Describe your childhood:

_____
_____
_____
_____

Parents & Sibling Relationships (ages of siblings) Describe current relationships

_____
_____
_____

Positive Support System: None___ Poor___ Adequate___ Exceptional____

Friends: No ___ Yes (quantity and quality) _____

Ever witness either parent being abused: No ___Yes___

History of Abuse (physical, sexual, emotional, verbal, etc.) _____
_____
_____

Medical History

(Please check if you have any of these conditions)

Diabetes___ heart disease___ History of Stroke___ lung disease___ Seizures___

Cancer___ Liver/Kidney Disease___ Hepatitis___ Thyroid Disease___ HIV/AIDS___

History of Head Trauma___ Chronic Pain___ Allergies___ Surgeries (type)_____

Any other conditions/disabilities_____

Education

Highest Level of Education: Grade School___ Middle School___ High School ___

Associates___ Bachelors___ Masters___ Doctorate___

Special Education: No___ Yes (please explain) _____

Military Service ____ Yes, which Branch? _____

Employment

Currently Employed: No ___ Yes (if yes, type of work, part/full time, position) _____

Sleep: how many hours per night _____

Sleep problems: □ going □staying asleep □waking early

Exercise, type and amount each week _____, other self-care: _____

Eating problems: □no problems □undereating □overeating □History of eating disorder

(For Women) How many Pregnancies____ How many births____

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Substance Abuse History

TYPE	FIRST USE	LAST USE	FREQUENCY

Alcohol_____

Cannabis_____

Cocaine_____

Methamphetamines_____

Hallucinogens_____

Inhalents_____

Nicotine/Tobacco_____

Opiods_____

Sedatives/Hypnotics_____

Other_____

History of Substance Abuse Treatment? No___ Yes (when/where) _____

_____

Legal History:

Arrested: No___ Yes (year)_____

Child Custody: No___ Yes (year)_____ Court Ordered Treatment: No___ Yes (year)_____

Risk Assessment

History of Suicide Attempts: No___ Yes___ (if yes give dates, method, and treatment?)

_____

Current Suicidal Ideation: No___ Yes___ (If yes do you have plans, intent or access to means)

_____

Past Suicidal Ideation: was there intent or a plan? _____

History of self-harm or injurious behavior? _____

Danger to self, risk factors and protective factors:

Risk Factors Please check all that apply

- ◊ Prior suicide attempts, aborted attempts, or self-injury behavior
- ◊ Repeated attempts with increasingly severity
- ◊ Started plan with intent
- ◊ Access to means (i.e., firearms, knives)
- ◊ Substance Abuse (current or past)
- ◊ History of suicide with friends or family
- ◊ History of physical/sexual abuse
- ◊ Ongoing medical illness (i.e., pain, terminal illness, central nervous system disorder
- ◊ Events leading to shame, humiliation, or despair (i.e., losses, financial, health)
- ◊ Social Isolation
- ◊ Extreme agitation or recent acts/threats of aggression
- ◊ Impulsivity
- ◊ Insomnia
- ◊ Increased anxiety/depression
- ◊ Lack of feelings
- ◊ Hopelessness
- ◊ Psychosis (hear voices, TV or radio telling you to do something. Seeing things that are not there?)

Protective Factors:

- ◊ Immediate supports
- ◊ Social supports
- ◊ Responsibility to pets or children
- ◊ Planning for the future
- ◊ Positive therapeutic relationships
- ◊ Ambivalence for living
- ◊ Core values

History of Harming

Have you ever harmed another? ___No ___Yes (if yes, please briefly explain the situation)

_____

Are you currently homicidal? ____No ___Yes

Most recent homicidal ideation. Was there a plan? _____

_____

Danger to Others? (Please circle all that apply)

- ◊ Prior acts of violence
- ◊ Fire setting
- ◊ Angry mood/agitation
- ◊ Arrest for violence
- ◊ Prior hospitalization for dangerousness
- ◊ Sense of purpose
- ◊ Ability to cope with stress/ frustration tolerance
- ◊ Access to means (weapons)
- ◊ Current or past substance abuse
- ◊ Psychosis
- ◊ Physical abuse as child
- ◊ Current psychosis stress