Bravely Blooming Consulting, LLC

ADULT CLIENT INTAKE INFORMATION FORM

How were you referred to Dr. Siler or *Bravely Blooming*? _____

Full Name: _____ **Date:** _____

Date of Birth: _____ **Age**: _____ **Gender**: _____ (Preferred Pronouns? _____)

Address:_____
(Street) (City) (State) (Zip code)

Relationship Status: Single; Partnered/Living alone; Live-in Partner; Married; Separated; Divorced; Widowed

Insurance Note: Bravely Blooming Consulting, LLC currently does not accept health insurance; but we are in the process of becoming credentialed in-network with a few select health insurance panels. Please share who your health insurance provider is (PPO or HMO), for future reference. Upon request, we will provide you with the information (CPT and diagnostic codes) you need to seek reimbursement for behavioral health services.

Primary Insurance Company: _____

Secondary Insurance Company: _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____ May I text you re: scheduling? Yes ☐ No ☐

Email: _____ May I Email you? Yes ☐ No ☐

Best method of contact for scheduling or rescheduling appointments:

Home: Yes ☐ No ☐ **Work:** Yes ☐ No ☐ **Cell:** Yes ☐ No ☐

May I leave a message on the answering machine? Yes ☐ No ☐

May I leave a message with someone at this number? Yes ☐ No ☐

Please list any restrictions: _____

***Whom may I contact in case of an emergency*?**

Name: _____ **Relationship:** _____

Phone: _____ Alternate phone: _____

Name: _____ **Relationship:** _____

Phone: _____ Alternate phone: _____

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ADULT CLIENT INTAKE INFORMATION FORM

Please briefly describe **the reason(s) for currently seeking current services**. Is there a specific style of therapy or skill set that you are most interested in? _____

_____

_____

_____

_____

_____

What do you think some of your strengths are?

_____

_____

_____

How would someone close to you describe you in 3 words?

_____

Household/Family Information

Member Name	Relationship to you	Birth Date M/F/Age	Education	Employed?
1.				
2.				
3.				
4.				
5.				
6.				

Is anyone else temporarily residing in the home? If so, please list their name(s)/age/gender.

_____

_____

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PLEASE MARK ALL AREAS OF INTEREST OR CONCERN THAT APPLY TO TREATMENT:

_____low self-esteem _____feel depressed _____feel anxious
_____ Fears/worries _____Sleep disturbance _____ infidelity/betrayal trauma
_____crying episodes _____fast heartbeat _____money problems
_____unable to have fun _____always worried _____relationship concerns/probs with romance
_____feelings easily hurt _____frequent sweating _____work difficulties
_____lacking in confidence _____ can't hold a job _____people say I work too much
_____identity concerns _____sexual orientation _____ gender identity exploration
_____Survivor of abuse _____ had alcoholic parents _____ military trauma
_____trust issues _____shaky hands _____ dizziness
_____feeling hopeless _____stomach trouble _____excessive drinking
_____impulsive _____nightmares _____excessive medication use
_____poor appetite _____feeling tense _____excessive drug use
_____act before thinking _____cold feet and hands _____problems with children
_____trouble sleeping _____feeling panicky _____problems with parents
_____loss of sexual interest _____sexual problems _____ erectile dysfunction/vulvadynia
_____feeling lonely _____diarrhea/constipation _____problems with coworkers/boss
_____ poor physical health _____loss of appetite _____shy with people
_____not enjoying things _____muscle twitching _____dislike my body
_____suicidal thoughts _____nausea or vomiting _____too much energy
_____ can't "get going" _____can't make decisions _____ can't get organized
_____can't make friends _____impatient with people _____ no one understands me
_____feeling angry _____headaches _____quick tempered/irritable
_____unable to relax _____social anxiety _____ perfectionistic tendencies
_____worried about health _____fainting spells _____lack energy
_____can't concentrate _____overly ambitious _____ history of cutting/burning
_____feeling inferior _____feeling fearful _____ always tired/exhausted
_____ very restless _____can't sleep well _____feel like hurting someone
_____don't like being alone _____panic attacks _____feel like smashing things
_____weight concerns _____excessive overeating _____binge eating
_____ restricted eating _____ pro-ANA tendencies _____ eating or meal prep rituals
_____ divorce proceedings _____ blended family _____ step-parenting stress
_____ deployment stress _____ immigration stress _____ unemployment stress/job threats
_____ career dissatisfaction _____ No sense of purpose _____ I hate my life right now
_____ "OCD" behaviors _____ grief due to loss/death _____ Racial identity/ethnic issues
_____limited social outlets _____ feel bored often _____ financial stress/mismanagement
_____ aging parents _____ caregiver/parenting stress _____ dissatisfying family relationships
_____ dependency issues _____ children have school problems _____ adult children have problems
_____ cancer related _____ autism spectrum related _____ family member with serious illness
_____ feel "checked out" _____ children have school problems _____ adult children have problems
_____ Could it be PTSD? _____ dissociative responses _____ sensory-integration problems
_____ attachment problems with loved ones _____ quarreling at home _____ partner/child substance abuse

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Rank the severity of your present concerns on your daily functioning (Circle one):
Not disruptive - Mildly disruptive - Moderately Disruptive - Very Disruptive - Severely Disruptive - A Crisis

How long have your current problems existed?_____
_____

Medical History & Relevant Background

Family MD/ Primary Care Physician: _____
Other Specialist Physician(s): _____

Medical Health History	Yes/No	Date of Onset	Medication Name
Asthma			
Allergies			
Concussion/Head Trauma			
Loss of Consciousness			
Fainting?			
Seizures?			
Headaches?			
Sleep Apnea			
IBS/Inflammatory Bowel			
Cardiology Concerns			
Congestive Heart Failure			
High Blood Pressure			
Diabetes/Neuropathy			
Tics/Twitching			
GERD			
Thyroid Concerns			
Cancer Treatment			
Rheumatoid Arthritis			
Fibromyalgia			
Autoimmune Disorder			
Liver Disease			
Menstrual Disturbance			
Post-partum Disturbance			
Reproductive concerns			
Self-Soothing disturbance			
Visual/Perceptual difficulties			
Hearing difficulties			
Movement difficulties			
Eating/Swallow difficulties			
Substance Use concerns			
Meningitis concerns			
Sensory Integration Disorder			
Processing Disorder			

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ADULT CLIENT INTAKE INFORMATION FORM

What, if any, other specific medical diagnoses or serious illnesses have you had?

_____

_____

Describe the impact on you related to any of your chronic health problems:

_____

_____

_____

Are you aware of any adverse side effects that you have experienced from current or previously prescribed medications?

_____

_____

Are you aware of any allergies or sensitivities to prescribed medications?

_____

_____

List any prior medical hospitalizations or surgeries: ☐ Mark this box if you need more space than is provided.

_____

(Reason for Hospitalization/Type of Surgery) Approximate Date(s) (Status)

_____

(Reason for Hospitalization/Type of Surgery) Approximate Date(s) (Status)

Behavioral Health History:

Have you ever had previous counseling, psychotherapy, or psychological evaluation? Yes ☐ No ☐

If "yes," by whom and when? _____

_____

Previous diagnoses and/or reason for previous treatment? _____

_____

_____

Was it helpful? Why/Why not? _____

_____

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ADULT CLIENT INTAKE INFORMATION FORM

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, etc.)?
Yes ☐ **No** ☐ I Discontinued my medication by choice ☐ Doctor discontinued my medication ☐

If yes, please list medication(s) and current dosage(s) or bring bottles to next session:

_____

_____

_____

Prescribing MD/Psychiatrist: _____ **Phone**: _____
Are you interested in coordinated treatment with your other medical providers? Be sure to complete the authorizations for release of information forms!

Have you ever acted on thoughts of self-harm? Yes ☐ No ☐ *If so, please explain preferences:*

_____

Have you ever made a suicide attempt/gesture? Yes ☐ No ☐ *If so, please explain:*

_____

Are you currently experiencing suicidal thoughts? Yes ☐ No ☐ *If so, please explain:*

_____

Please rank your perceived risk of acting on these thoughts from 0- 10:
0 - Things are bad sometimes but I want to live.
3 - I could never really go through with hurting myself because of my loved ones, my beliefs, etc.
5 - I wish to escape my situation, not to die
7 - I have thought about how I would plan to die, but I do not intend to act on those thoughts.
9 - I have planned out how I would do it; and I currently don't know whether I will keep myself safe.
10 - I have planned out how I would do it; and part of my reason for coming is to get help because I don't think that I can keep myself safe.

Have you ever been psychiatrically hospitalized? Yes ☐ No ☐

Hospitalization #1:_____ Approximate dates: _____

Reason for Admission: _____

_____

Treating Physician/Psych:_____

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ADULT CLIENT INTAKE INFORMATION FORM

Hospitalization #2:_____ Approximate dates: _____

Reason for Admission: _____
_____

Treating Physician/Psych:_____
Note: *Please fill out one form for each provider who has given you psychotherapy, psychiatry, medications and/or any other mental health treatment in the past. Indicate whether you would like me to request previous records to have on file.*

Responsible Party Payment Agreement/No Show or Late Cancel Agreement:

Your full amount for fee-for-service payment is expected at the time services are rendered. Payments can be accepted by: cash, check made out to Bravely Blooming Consulting LLC, Chase Quick Pay electronic funds transfer, CC payment, PayPal.

Name of Person Responsible for Payment: _____
Responsible Party's Date of Birth: _____
Responsible Party's Address: _____

I hereby authorize treatment for the patient listed above and accept the responsibility for the charges incurred for this treatment or assessment, regardless of any other arrangements with third parties, including insurers. I also understand that if I do not give 24 hours notice when canceling an appointment, I will be charged a $60 **late cancel cancellation fee** or **no show fees are the full cost of the session**. Phone consultations of 15 minutes or longer may also be billed to my account and insurance in accordance with fee schedule. In the unlikely event that a patient fails to remit payment and the credit card is denied, *Bravely Blooming Consulting, LLC* will notify you of your outstanding balance, and request payment prior to sending your account to collections and/or the pursuit of legal action. Patients will be held responsible for all associated fees, including, but not limited to, the cost of collection services, attorneys, administrative support, and therapists' time.

_____ _____
Signature Date

Note to Teens & Young Adults: If you are under 18 years of age, please be aware that your parents or legal guardians have a right to receive general information on the progress of the treatment and may have the right to access your chart in its entirety. If you are over 18, and you want to waive your right to confidentiality in order for your parent or legal guardian to have access to your attendance information, clinical records, or assist you in decision making and payment. **Please sign below and note that your signature indicates that you are providing written consent to authorize Dr. Siler or *Bravely Blooming* staff to exchange some information with your parent or legal guardian**.

_____ _____
Signature Date
Name of authorized parent or legal guardian: _____

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Receipt of HIPPA/Review of Bravely Blooming practice policy/Termination information

My signature below indicates that I have reviewed and understand the HIPPA documents, informed consent treatment agreement, limitations to confidentiality, and related practice policy documents. These documents are available on the website for me to review at any time. I understand that I may ask my therapist questions about confidentiality or treatment limitations throughout the course of treatment, and that I am free to discontinue treatment at any time. My signature below indicates that I am aware that this outpatient private practice is NOT an emergency service. I am aware that if I am in a crisis situation or clinical emergency, I should proceed to the nearest emergency room and have them contact Dr. Amber Siler.

If my choice to terminate treatment is against medical advice by my therapist, I agree to provide my therapist with a written explanation for why I am choosing to terminate services. My signature below indicates that I am aware that my therapist also reserves the right to unilaterally terminate services, but will attempt to provide me with referrals to other providers. Circumstances that may result in referral to another provider or immediate termination of treatment include but are not limited to: the current treatment appears to be ineffective; the therapist does not believe he/she has the necessary training to address a specific problem; I or my family member made threats made against the therapist or his/her family; stalking behaviors; or if there is a significant therapeutic impasse. In such cases, the therapist will attempt to provide a suitable referral; however, the therapist is not responsible as to whether I comply with treatment recommendations or whether the referrals are accepted.

_____ _____

Patient Signature (Or parent/guardian if patient is under 18 years of age) Date

Consent for Electronic Contact via E-Mail

Preferred Email Address to keep on file: _____

My consent to be in contact via email indicates that I am aware that email is not a secure means of communication. I am aware that it is best for my personal information or discussions of my private health information to occur during face to face sessions to reduce the risks to my privacy or confidentiality. At times, my therapist may offer to email me links to resources or referrals to other providers. Email may also be used for scheduling purposes. My signature below indicates that I am aware of the potential risks of using email as a method of communication, and I do not hold my therapist liable for unforeseeable problems or unanticipated risks due to email servers and usage. I have the right to refuse to use email contact as a method of communication at any time. My therapist reserves the right to refuse to use email as a method of communication at any time as well.

If I consent to use email as a method of communication, I am aware that my therapist is not available to respond to email 24h/day and as such, email is not an effective way to communicate emergency information. I am aware that my therapist reserves the right to take up to 3 business days to respond to an email, and may also choose to respond to emails that I write via phone or during a face to face session. The email address that I am providing is private and not shared or accessible by any other person than myself.

_____ _____

Patient Signature (Or parent/guardian if patient is under 18 years of age) Date

_____ _____

Clinician Signature Date

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Authorized Permission for Release/Request of Confidential Information

Patient Name: _____
Patient Date of Birth: _____
Person Authorized to give permission: _____
Relationship to patient: _____

I give permission for Dr. Amber Siler, and or appropriate staff at *Bravely Blooming Consulting, LLC* to communicate with and exchange information, if necessary, regarding personal, educational, medical, psychiatric, and/or psychological treatment.

_____
(name of the specialist/agency/institution) Relationship to Client

_____
(contact information - address)

_____
(contact information – office phone) (office fax number)

This information will be used for evaluation, treatment, or psychological consultation regarding the patient listed above. The above permission includes oral communication and exchange of relevant patient information, including but not limited to, summaries of treatment, copies of records, and diagnosis, when necessary. This permission is granted for 365 days, however, we request that an updated form be placed in the client file at the start of each new calendar year.

_____ _____
Signature of Authorized Person Granting Permission Date

_____ _____
Clinician Signature Date