i TO i COUNSELING

Chris Quaglino, LCSW, LCDC (512)775-5940

Client Intake Information Form

I want to assure you that I read every bit of the information you give me. Thank you for your time and information.

Also, Failure to provide 24-hour notice or no shows will result in a $45 charge.

Name:		Date of Birth:	
Client Name if Different than person completing this form:		Date of Birth:	
Address:	City:	State:	Zip:
BCBSTX PPO Member ID:	Group ID:		Age:
I agree that Chris Quaglino can bill my insurance company and understand that if my insurance company requests mental health updates he may be required to supply this information.			Initial Here:

***Optional Demographic Information**								
Gender:	☐ Female	☐ Male	Please denote preferred pronoun:					
Client Contact Information and Permissions: **You are responsible if others access your electronic communication with me or if they look over your shoulder.** **Also note that electronic communication can be subpoenaed and is a permanent record.**								
Home Phone:			Can I leave a message at home?		Yes		No	
Personal Cell Phone:			Can I leave a message on your cell?		Yes		No	
			Can I text message to this cell phone?		Yes		No	
Email:			Can I send you emails?		Yes		No	
Work Cell Phone: (**Work property use is not recommended**)			Can I leave a message on this work phone?		Yes		No	
			Can I text message to this cell phone?		Yes		No	
Work Desk Phone: (**I do not leave messages on desk phones**)			Companies can access personal desk phone messages					
Work Email: ----------(**Do not use work email**) ----------			Email creates a permanent record of your personal business					
Please check all that apply:	☐ Single	☐ Married/Partnership	☐ Divorced/Separated	☐ Widowed				
Emergency Contacts								
Name:			Relationship to you:					
Best Phone Number (Daytime):			Best Phone Number (Nighttime):					
Address:			City:	State:	Zip:			

Family Information				
	Name(s)	Age(s)	Name(s)	Age(s)
(Ex)Spouse/Partner				
Children				
Siblings				
Parents				
Are there other family members in the home?	☐ Yes ☐ No	Explain:		

Employment								
Employed:		Yes		No	Occupation?			
Combined Household Income: ☐ Below $16,000/Year	☐	Between $16,000.00-$25,000.00/Year	☐	Between $25,000.00-$50,000.00/Year	☐	Between $50,000.00-$100,000.00/Year		

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Symptom Checklist: Please check the symptoms that you are experiencing and indicate the severity and frequency. Check only those that apply.

Symptoms	Indicate Severity (mild, moderate, severe)	Indicate Frequency (daily, weekly, monthly)	Comments
Depressed mood	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Grief / bereavement	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Hopeless / helpless	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Decreased energy / Fatigue	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Hyperactivity	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Mood Swings	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Weight or Appetite Change	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Irritability / Restless	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Sleep Disturbances	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Obsessive or Compulsive Behavior	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Flashbacks	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Paranoia	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Anxiety/panic attacks/ worrying	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Suicidal Thoughts	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Impaired concentration	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Loss of interest in activities	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Self-Harm-Cutting/Burning/Other	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Binging/Purging/Restricting Food	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Anger Issues	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Current Abuse	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Delusions / Bizarre Beliefs	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Hallucinations	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Impaired Memory	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Gambling Problem	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Sexual Issues	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Internet or porn addiction	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Other:	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Legal Issues	☐ mild ☐ moderate ☐ severe	☐ daily ☐ weekly ☐ monthly	
Anything else I need to know?			
List strengths:			

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Mental Health History				
Name of your Doctor (PCP):				
Address:		City:	State:	Zip:
Date of last appointment:		Date of next appointment?		
Diagnosis (Past and Present):				
Name of your Psychiatrist, Nurse Practitioner:				
Address:		City:	State:	Zip:
Date of last appointment:		Date of next appointment?		
Diagnosis (Past and Present):				
What medications are you currently taking?				
Name of Rx:	Dosage:	When started?		
Please note here (i.e. side effects, allergies, poor efficacy):				
Name of Rx:	Dosage:	When started?		
Please note here (i.e. side effects, allergies, poor efficacy):				
Name of Rx:	Dosage:	When started?		
Please note here (i.e. side effects, allergies, poor efficacy):				
List any other medical concerns I may need to know here (history of Rx, trauma, physical ailments):				
Have you ever had previous psychological counseling or treatment?			Yes	No
Dates of service (from? to ?)		Name of Provider or Hospital/Clinic		

Safety Issues/Concerns (Past and Present)				
Do you have a history of suicidal/homicidal ideation or attempt(s)? (include self-harming issues)		Yes		No
Dates	Details			
Are there immediate suicidal/homicidal concerns?		Yes		No
If yes, please explain:				

Drug, Substance, and Alcohol Use (include Rx abuse)				
Are there current or past issues and/or concerns with drugs and/or alcohol?		Yes		No
If yes, please explain: (history, current use, substance, and anything else I may need to know that would be helpful to our sessions)				

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Pre-Service Questionnaire
The process of therapy can be stressful and sometimes overwhelming. To help this process to be as productive as possible, an important therapeutic partnership must be established between you and your therapist in which good self-care routines are established. Please help me to understand more about you by providing the information listed below:
Please list the top areas of current concern for you that you would like or need to work on:
Please tell me a little bit about your history (pertinent information concerning your family and relationships history, significant losses):
Do you feel like you have resolved any of these issues? How?
Have you suffered a traumatic event? Please Circle: Car Crash Natural Disaster Assault Deployed Military Service Other (describe). If yes, what and when?
What do you hope to get out of our sessions?

Notice of Cancellation Policy

Your appointment time is held for you every week and will be confirmed after each session. If you need to make any changes to your appointment, please give at least 24-hour notice. **Failure to provide 24-hour notice or no shows will result in a $45 charge** which is one half of the full session rate. Please be on time for your appointments. Showing up more than 15 minutes late to the appointment may result in needing to reschedule the session. Your session starts at the time scheduled and ends 50 minutes from that time. If you are late, please understand that I must end the session as scheduled so that I can complete administrative tasks and start on time for the next client. Payments are due at the start of each session or can be paid in advance. Payment for services is an important part of any professional relationship. It shows that you value your healing and personal development.

How did you hear about me? (please include name if appropriate)

☐ www.itoiaustin.com	☐ Conference/Seminar
☐ Friend/Family	☐ Yelp
☐ NetworkTherapist.com	☐ Psychology Today website
☐ Google search	☐ Yahoo search
☐ M.D./Counselor	☐ HelpPro website
☐ Other	

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Confidentiality and Notice of Privacy Practices

Overview
As a clinician, I am committed to providing services that enhance the well-being of my clients. I recognize that the people I serve must provide personal information in order for my services to be effective and that I have an obligation to protect my clients' privacy and use this information ethically and appropriately at all times. As such, personal information about my clients should be obtained and used only when necessary. I believe that individuals have a fundamental right to privacy and that it is my obligation to ensure information is protected whether it exists in hard copy form, in electronic form or is communicated to other professional staff.

Informed Consent
I hereby acknowledge that I have read and understand the following six items concerning confidentiality of service provided. I understand that if I have any questions regarding privacy rights, I can contact Chris Quaglino, LCSW, LCDC.
I understand that the communication in my sessions is privileged and Chris Quaglino will maintain confidentiality with the following exceptions:

1. I sign a Release of Information form authorizing Chris Quaglino to share specified information with only persons identified in said authorization. Also, this authorization is time limited to a maximum of 6 months from the time of signature.
2. If there is a Court order, from a judge, to disclose your information. (a fee of $225/hr. will be charged for court testimony).
3. If you are threatening eminent/plausible physical harm to yourself or to others.
4. If you tell me of neglect, physical or sexual abuse of a child, disabled or elderly person. I am required to report such to the Texas Protection Services.
5. If you tell me of misconduct of a therapist, minister or a person of authority, I am required to report it to the proper board.
6. If you are utilizing your insurance or are asking for reimbursement for your services, a diagnosis and pertinent therapeutic information may need to be disclosed to the insurance company for you to be reimbursed.

If you have any questions or concerns, please share them with me.

Receipt and Acknowledgment of Notice
I hereby acknowledge that I have received and have been given an opportunity to read a copy of these offices Notice of Privacy Practices (HIPAA). I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Chris Quaglino at the above address.

Notice of Privacy Practices

I am required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is presently effective and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. The HIPPA Notice of Privacy Practices is posted at www.itoiaustin.com under the Forms page. You may request a written copy of a revised Notice of Privacy Practices from this office if you do not have internet access. In the event of any change to my privacy practices, I will provide you with an updated version in a timely fashion.

You have recourse if you feel that your privacy protections have been violated. Please notify me as soon as possible with any concerns/ You have the right to file a formal, written complaint with us at the address below and your concerns will be immediately addressed. Or, with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

For more information about HIPAA or to file a complaint, please contact the following:

Chris Quaglino, LCSW, LCDC
1507 North Street Unit 1
Austin, Texas 78756
(512) 775-5940

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257

Signature:	**Date:**