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.

If you are part of any current or up and coming legal proceedings or court cases, including divorce or separation please specify:

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. Please complete the Client Communications Agreement at the bottom on page 5.

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:

Optional Employment/Income Information								
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. Please check all that apply.

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

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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 loss):
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.

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Client Communications Agreement Communication Policy

The Health Insurance Portability and Accountability Act (HIPAA) gives you, the client, the right to request that your therapist communicates administrative and/or clinical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please indicate how you wish to be contacted. **Check and fill in all that apply**:

	Phone Communication
⬇	Place an 'X' in each column that you choose
	Home Phone Number: _____ I understand Chris Quaglino will not leave a message that others may hear.
	Personal Mobile Phone Number (NOT A WORK PHONE):
	Yes, Chris Quaglino may leave a message with his name and call-back # on my voicemail because I have my phone password protected and I don't share the password with anyone.
	I also agree to **only use text for appointment confirmation**. I will not use texting for discussion of any issues or concerns. I will call Chris Quaglino directly with this type of information, leave a message as needed, and Chris Quaglino will return my call. And finally, I know that **if I leave my phone or computer out and/or unlocked for others to see or use, I may compromise the privacy of my personal information. It is my responsibility to keep the information on my electronic devices private. This includes all electronic devises: iPad, Phone, Tablet, Computer, TV incoming calls notices, etc.**

	Email Communication
	I do not wish to communicate via email.
	Yes, I wish to communicate via email. I will **ONLY USE the private, personal email address listed below. I will never use a shared or work email address**. I also understand that work email is the property of the company that I work for and can be used in court. My secure/personal email address is:

	Acknowledgements
⬇	Please **initial each space** below acknowledging you have been given access to, read and understand the following:
	HIPAA Statement (*separate document on www.itoiaustin.com*)
	Informed Consent Statement (*separate document on www.itoiaustin.com*)
	Teletherapy Informed Consent Statement (*separate document on www.itoiaustin.com*)
	Communication Agreement (*Phone and Email section above*)
	Notice of Cancellation Policy (*on the bottom of page* 4)
Client Name (please print)	Client Signature (or authorized representative*) Date

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

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