Clt #______________ Peaceful Family Solutions

INTAKE FORMS

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female
Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

SOCIAL SECURITY # ___________________________

Please list any children/age:
____
____

Address:
____
(Street and Number)
____
(City) (State) (Zip)

Home Phone: _________________________ May we leave a message? ☐Yes ☐No

Cell: _________________________________ May we leave a message? ☐Yes ☐No

Work Phone: __________________________ May we leave a message? ☐Yes ☐No

E-mail: _______________________________________ May we email you? ☐Yes ☐No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any):
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner:
____

Are you currently taking any prescription medication?

☐ Yes

☐ No

Please list:

____

____

Have you ever been prescribed psychiatric medication?

☐ Yes

☐ No

Please list and provide dates:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in: ________________________________

4. Please list any difficulties you experience with your appetite or eating patterns.

____

____

5. Are you currently experiencing overwhelming sadness, grief or depression?

☐ No

☐ Yes

If yes, for approximately how long? _________________________

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6. Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ No ☐ Yes
If yes, when did you begin experiencing this? ____________________________

7. Are you currently experiencing any chronic pain?

☐ No ☐ Yes
If yes, please describe? ____________________________

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly

☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? ___________________
On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle List Family Member		
Alcohol/Substance Abuse	yes/no	____________________________
Anxiety	yes/no	____________________________
Depression	yes/no	____________________________
Domestic Violence	yes/no	____________________________
Eating Disorders	yes/no	____________________________
Obesity	yes/no	____________________________
Obsessive Compulsive Behavior	yes/no	____________________________
Schizophrenia	yes/no	____________________________
Suicide Attempts	yes/no	____________________________

ADDITIONAL INFORMATION:
1. Are you currently employed? ☐ No ☐ Yes
If yes, name and address of your employer:

____

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief:

____

____

3. What do you consider to be some of your strengths?

____

____

____

4. What do you consider to be some of your weakness?

____

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

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HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME ____
2. STREET ADDRESS ____
3. CITY _________________________________
4. STATE & ZIP CODE ______________________
5. PATIENT'S DATE OF BIRTH __________________
6. TELEPHONE __________________________
7. PATIENT'S SEX M_____ F_______
8. PATIENTS' RELATIONSHIP TO INSURED:
   SELF___ SPOUSE____ CHILD_____ OTHER______
9. PATIENTS' STATUS:
   SINGLE____ MARRIED___ OTHER_____
   EMPLOYED_____ FULL-TIME STUDENT_______ PART-TIME STUDENT_____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. NAME OF INSURED _______________________________
2. STREET ADDRESS OF INSURED _______________________________
3. CITY _________________________________
4. STATE & ZIP CODE ______________________
5. INSURED'S DATE OF BIRTH __________________
6. SOCIAL SECURITY # ____________________________
7. TELEPHONE __________________________

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8. INSURED’S PLACE OF EMPLOYMENT: ___________________________________

9. INSURANCE PLAN NAME OR PROGRAM NAME. _________________________

10. INSURED’S INSURANCE ID NUMBER_________________________

11. POLICY GROUP NUMBER _______________________

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Brent Katigan LADC/MH, and authorize Brent Katigan LADC/MH to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

____ Date ___________
Signature of Insured

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Clt #______________________

Brent Katigan MA, LADC/MH

Statement of Professional Disclosure

I am required by law to furnish you with information about my professional credentials

- Licensed Drug Alcohol and Mental Health Counselor Lic. # 992
- Certified Suicide Prevention Trainer
- Eye Movement Desensitization & Reprocessing (EMDR) under supervision
- Problem Gambling Counselor, Under Supervision
- Master of Substance Abuse Studies
- Bachelor in Social Work
- Graduate Work in Social Work

I understand therapy to be a process of growth, healing and education. You are the expert on your life; my expertise is the tools I offer. My role is to guide the process by offering observations, questions, alternatives and guiding your exploration. Agreements between you and me are part of this work. Agreements include: goals, limits, duration and depth of work to be accomplished.

Exceptions to confidentiality include: signing a release so that information can be provided to a third party; consultation with my supervisor and professional peers; and situations involving safety – yours or someone else's.

To help people recover I blend talking with activities and recommend practicing new skills between sessions. I enjoy helping people grow and change. I look forward to working with you.

Should you wish additional information, please ask me. You may also contact (without giving your name):

Oklahoma State Board of Licensed Alcohol and Drug Counselors
101 NE 51st St : : Post Office Box 54388 :: Oklahoma City, OK 73154-0817
Tel: (405) 521-0779 :: Fax: (405) 521-0291
Executive Director Email: rpierson@okdrugcounselors.org
Administrative Assistant Email: cwaite@okdrugcounselors.org

______________________________ ______________________________
Brent Katigan MA, LADC/MH Date

The above-signed counselor has satisfactorily supplied me with information regarding her professional credentials and has given me a copy of this disclosure statement.

______________________________ ______________________________
Client Signature Date

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Clt #______________________

PEACEFUL FAMILY SOLUTIONS
HEALING AND PREVENTION SERVICES FOR FAMILIES OF ADDICTION

CONSENT TO TREATMENT/FOLLOW UP

Client:____ Date:____________________

Email Address: ____

I, the undersigned, voluntarily give my consent for counseling and to be interviewed by the Peaceful Family Solutions Staff.
Peaceful Family Solutions occasionally contacts a client by phone, mail, or email to determine satisfaction with our services or other information. If you DO NOT want to be contacted for this follow-up information at work or home phone, by mail, or by email please indicate here:

- Appointment information may be relayed to:________________________________
- I prefer this number to be used for appointment information: __________________
- Office staff or counselor may contact me to follow up on services by:
  (Please mark your preference)

  - O Phone
  - O Letter
  - O Email

OR

O I do NOT want to be called or written to by Peaceful Family Solutions.

Peaceful Family Solutions may call you regarding appointments.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Staff Signature Date

For Office Use Only

*Client:*___________________________*Ct#:*______________*Date:*_______________

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Peaceful Family Solutions
Authorization to Release Information Form

I, ____________________________, authorize: Name/Program: ____________________________________

DOB: ____________ Address: ____

City/State/Zip:______________________________________

Telephone: ____

to exchange information in my records with: ____

Program: Peaceful Family Solutions

Person/Relation: ________________________

Address: 7405 S. Douglas Ave, Oklahoma City, OK 73044.

Telephone: 405-601-2691 Fax-405-601-2773

I understand that my alcohol and drug treatment records are protected under federal regulations governing Confidentiality and Alcohol and Drug Abuse Client Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **I understand that my medical record may contain information concerning my psychiatric, psychological, drug and/or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions or communicable diseases**. Treatment Services are not contingent upon or influenced by the consumer's decision to permit the information release advised or requested.

INFORMATION TO BE EXCHANGED: (Check all that apply) DATES OF TREATMENT from _________ to __________.

- ☐ Presence in Treatment (admit/discharge dates)
- ☐ Medical History and Physical Examination
- ☐ Health Records
- ☐ Diagnosis, Brief Description Progress/Prognosis
- ☐ Discharge Summaries/Continuing Care Plan
- ☐ Nursing Assessment
- ☐ Admission
- ☐ Multi-Disciplinary Treatment Team Progress Notes
- ☐ Other: ___________________________________
- ☐ Biopsychosocial/Diagnostic Summary
- ☐ Admissions Profile
- ☐ Concerned Persons Questionnaire
- ☐ Multi-Disciplinary Treatment Plan
- ☐ Psychological Evaluation
- ☐ Physician Attestation Statement
- ☐ Psychiatric Assessment
- ☐ Info Necessary for the Processing and Payment Of Billing
- ☐ Regular Updates

PURPOSE OF RELEASE:

- ☐ To Provide Ongoing Treatment/Continuing Care
- ☐ To Provide Education Services
- ☐ To Coordinate Treatment Efforts With My Family/Significant Other/Concerned Person
- ☐ Biopsychosocial/Diagnosis Summary
- ☐ Coordinates Services With Authorized School Officials
- ☐ To Coordinate Treatment and Continuing Care Efforts With My Employer/Employee Assistance Program
- ☐ To Coordinate Vocational Training With Vocational Training officials.
- ☐ To Enable Judges, Attorneys, Probation/Parole Officers, To Support My Treatment Goals Or To Make Legal Decisions On My Behalf.
- ☐ To Allow Insurers To Resolve the Pendency Of Claims For Facility/Program Billed Services.
- ☐Other

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, and, in any event, this consent automatically expires one year after the consent form is signed which will be_________.

Client Signature: ____ Date: _______________________

Parent/Guardian Signature: _______________________________________ Date: _______________________

Staff Witness: ____ Date: _______________________

Prohibition on Re-disclosure of Information Concerning Clients in Alcohol or Drug Abuse Treatment

This notice accompanies a disclosure of information concerning client in alcohol/drug abuse treatment made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rule 42 CFR, Part 2. The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical and other information is not sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute and alcohol or drug abuse client.

I wish to revoke this consent, effective ________________. Client Signature: ____________________________________.

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