Keith Jordan, LCSW

Offices: 1131 Route 55, Suite 1, Lagrangeville, NY 12540
20 Milton Avenue, Highland, NY 12528
Phone: (845) 345-8956 Email: keith@keithjordanlcsw.com
Website: www.keithjordanlcsw.com

INTAKE QUESTIONNAIRE

Full name: _____ Sex: ____ Birthdate: _____

Mailing address: _____, _____, ____ _____
Street address City State Zip

Phone: _____ Best hours to call: _____

Email: _____

Persons living with you:

Name	Age	Relationship	School or employer

Ancestry (check all that apply):

_ African	_ Dutch	_ Irish	_ Mexican	_ Polish
_ Asian	_ English	_ Italian	_ Puerto Rican	_ Russian
_ American Indian	_ German	_ Middle Eastern	_ Other Hispanic	_ Other: _____

Religion:

_ Atheist	_ Jewish	_ Catholic	_ Methodist	_ Other Christian
_ Agnostic	_ Muslim	_ Episcopal	_ Lutheran	_ Other Non-Christian
_ Buddhist	_ Unitarian Universalist	_ Baptist	_ Presbyterian	_ Unsure/Unspecified

Health insurance company: _____ Policy number: _____

How did you learn of my services? _____

Please describe the situations and issues you want help with:

_____

_____

_____

Childhood And Family Of Origin

Where and with whom did you live between the ages of 0-18? Please indicate how old you were when there were changes in where you lived or with whom.

Where do these family members live now, and what type and frequency of contact do you have with them?

How were you disciplined when you were a child?

How do you think the way you were raised and your childhood circumstances and experiences have affected your life as an adult, including your choices and behaviors?

Education History

School	Dates of Attendance	Degree or Reason for Leaving

Military Service

Branch of Service	Enlistment Date	Date of Basic Training	Advanced Training	Position	Discharge Date	Type of Discharge

Present Employer: _____ Job title: _____

Past Employment History

Position	Employer	Year Started	Year Left	Reason for Leaving

Marriage History

Name of Spouse	Date of Marriage	Date of Separation	Date of Divorce

Residential History

Street Address and City	Dates	Reason for Leaving

Mental Health/Substance Abuse Treatment History

Facility	Therapist	Dates of Treatment	Phone Number

Please list the diagnosis you were given during your treatment, if known and the names of mental health medications that you were prescribed.

_____

_____

_____

Are you currently taking any mental health medication? Please list type, dosage and when taken.

_____

_____

_____

Alcohol and Other Substance Use History

Substance	Age of first use	Date of last use	Frequency	Amount per use

Physical Health History

Significant medical history:

_____

_____

Physician's name: _____ Phone: _____

Please list names of medications you take for physical health problems, dosages, when taken and reason taken.

_____

_____

_____

Arrest History

Date Arrested	Charge	Convicted (yes/no)	Sentence	Probation/Parole? (yes/no)

Probation/Parole Officer: _____ Phone: _____

Symptoms: Please check any symptoms or experiences that you have had in the last month: ☐Difficulty falling asleep ☐Difficulty staying asleep ☐Difficulty getting out of bed ☐Not feeling rested in the morning ☐Loss of interest in previously enjoyed activities ☐Withdrawing from other people ☐Spending increased time alone ☐Depressed mood ☐Feeling numb ☐Rapid mood changes ☐Irritability ☐Anxiety ☐Panic attacks ☐Frequent feelings of guilt ☐Frequent worry ☐Avoiding people, places, activities or specific things ☐Difficulty leaving your home ☐Fear of certain objects or situations (such as flying, heights, bugs) ☐ Repetitive behaviors or mental acts (such as counting, checking doors, washing hands) ☐Outbursts of anger ☐Feeling worthless ☐Hopelessness ☐Sadness ☐Helplessness ☐Feeling or acting like a different person ☐Changes in eating/appetite ☐Eating more ☐Eating less ☐Dizziness ☐Voluntary vomiting ☐Use of laxatives to lose weight ☐Excessive exercise to avoid weight gain ☐Binge eating ☐Difficulty catching your breath ☐Increased muscle tension ☐Unusual sweating ☐Difficulty concentrating or thinking ☐Easily startled, feeling "jumpy" ☐Increased energy ☐Decreased energy ☐Tremors ☐Racing thoughts ☐Intrusive memories ☐Large gaps in memory ☐Flashbacks ☐Nightmares ☐Thoughts about harming or killing yourself ☐Thoughts about harming or killing someone else ☐Feeling as if you were outside yourself, detached, observing what you are doing ☐Feeling puzzled as to what is real and unreal ☐Persistent, repetitive, intrusive thoughts, impulses, or images ☐Inappropriate expression of anger ☐Self-mutilation/cutting ☐ Excessive drinking ☐ Use of illegal drugs ☐ Abuse of prescription drugs

Please check the degree of problem you are experiencing in each of the following areas and describe what the specific issues are in each area.

Problem Area	No Problem	Slight Problem	Serious Problem	Description of situation and issues
Health				
Alcohol/drugs				
Marriage/relationship				
Family life				
Sexual concerns				
Social/interpersonal				
Recreation/leisure time				
Education				
Job/career				
Finances				
Spirituality/religion				
Management of emotions				
Thought patterns				
Inappropriate behavior				
Living environment				
Effects of difficult childhood				

PLEASE CHECK ONE AND SIGN:

___ I have completed this questionnaire myself
___ I completed this questionnaire with the assistance of another person. (Please specify
___ the name of the person and type of help) _____

Signed: _____ Date: _____

Please print your name: _____

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Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks: Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings and discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality: What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect: If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults: If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances: Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers: Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

Cancelation Policy

If you are unable to attend an appointment, I request that you provide at least 24 hours advance notice. Since I would be unable to use this time for another client, please note that **you will be charged $40 for your scheduled appointment if it is not canceled at least 24 hours in advance**. I may waive the fee if I determine that the cancelation is due to an emergency. I may also waive the cancelation fee if you are able to reschedule your appointment to a time within 3 days of your original appointment.

I appreciate your consideration in keeping your appointments or canceling as far in advance as possible in order to keep the office schedule running in a timely and efficient manner.

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By signing below, I am stating that I have received the *Consent for Treatment and Limits of Liability*. I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

In signing below, I am stating that I have read and understand the Cancelation Policy

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

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Mental Health Privacy Practices/HIPAA Requirements

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law (Public Law 104-191), passed by Congress in 1996 that, among other things, protects an individual's right to keep and/or transfer his or her health insurance when moving from one job to another and sets out certain administrative procedures, like ensuring the privacy of an individual's protected health information and providing security for electronic data sharing of protected health information.

As a therapist I am ethically and legally required to protect the confidentiality of my clients. Information will not be shared without written permission from the client or, if the client is a minor under the age of eighteen, the client's parent or legal guardian.
There are, however, conditions under which a client's confidentiality is released or not protected. These include:

- Suspected child abuse or dependent adult or elder abuse, for which the provider is required by law to report this to the appropriate authorities immediately.
- If a client is threatening serious bodily harm to another person(s), the provider must notify the police and inform the intended victim.
- If a client intends to harm himself or herself, the provider will make every effort to enlist the client's cooperation in ensuring their safety. If the client does not cooperate, the provider will take further measures without the client's permission that are provided by law in order to ensure the client's safety.
- Information is released directly to the court for court-ordered evaluations or court testimony.

Please note: Insurance companies request that the client release information to them for certification of services or reimbursement.

My therapeutic visitation services are not considered to be therapy and are not bound by the confidentiality of therapy. Information about what is said and done during therapeutic supervised visitation will be provided to individuals and agencies such as Family Court that have a reason to have such information.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

1. My commitment to you: I understand that the information I collect about you and your health and mental health is personal. Keeping that information confidential and secure is one of my most important responsibilities. I keep a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. I am committed to protecting your health information and to following all state and federal laws regarding the protection of your health information. This Notice of Privacy Practices describes how I may use and disclose your protected health information to carry out treatment and payment and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information," is information about you that may identify you and that relates to your past, present or future physical or mental health condition or care.

It is my responsibility to:

♦ make sure that health information that identifies you is kept private

♦ give you this notice of my legal duties and privacy practices with respect to health information about you

♦ follow the terms of the notice. If you have any questions about this notice, please contact me.

2. Your Health Information Rights: You have the following rights regarding the health information I have about you:

♦ You have the right to inspect and obtain a copy of health/mental health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. To inspect or obtain a copy of health information that may be used to make decisions about you, you must submit your request in writing or by email to Keith Jordan at keith@keithjordanlcsw.com. I may charge a fee for the costs of copying, mailing, or other supplies associated with your request. I may deny your request to inspect and obtain a copy in very limited circumstances.

♦ If you feel that the health information I have about you is incorrect or incomplete, you may ask me to amend that information. I may deny your request if you ask to amend information that: (1) was not created by me; (2) is not part of the health information kept by me; (3) is not part of the information which you would be permitted to inspect or copy; or (4) is determined to be accurate and complete. You have the right to request an amendment for as long as the information is kept by or for me. To request an amendment, your request must be made to me in writing or by email. In addition, you must provide a reason that supports your request.

♦ You have the right to request a list of information releases that I have made of your health information. The list will not include: health information releases that were made: (1) for purposes of providing treatment to you, obtaining payment for services, or for other administrative or operational purposes; (2) for national security purposes; (3) to correctional and other law enforcement custodial situations; (4) based on your written authorization (5) to persons who are involved in your care; or (6) before April 14, 2003. To request this list or accounting of disclosures, you must submit your request in writing or by email to me. Your request must state a time period, which may not be longer than 6 years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

♦ You have the right to request a restriction or limitation on the health information I use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that I restrict or limit health information about you that I may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. For example, you could ask that I not use or disclose information about the medication you are taking to your spouse or significant other. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you with emergency treatment. There is one exception to this: if you have paid for your treatment in full or out of pocket, and request a restriction on disclosures for payment or health care operations purposes to your health plan, I must agree to your request.

To request restrictions, you must make your request to me in writing or by email. In your request, you must tell me: (1) what information you want to limit; (2) whether you want to limit my use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

♦ You have the right to request that I communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that I only contact you at a certain phone number or by mail. To request confidential communications, you must make your request to me in writing or by email. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

♦ If there is a breach of your unsecured protected health information (which generally means your health information is not encrypted or otherwise can be read by anyone who looks at it), I must notify you that this has occurred.

♦ You have a right to a paper copy of this notice, which you may request at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact me in writing or by email. You may also obtain a copy of this notice at my website, www.keithjordanlcsw.com.

3. How I may use and disclose health information about you:

Your health information, which includes any information that relates to your past, present, or future health/mental health condition (which might include your photograph), may be used and released by me for the purposes of providing treatment to you, obtaining payment for services, for administrative and operational purposes, and to evaluate the quality of the services you receive.

I may release information about you to your health plan or health insurance carrier to obtain payment for my services.

I may also share your information, when appropriate, with government programs such as Workers' Compensation, Medicaid, Medicare, or Indian Health Services to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. I may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but I will only do so as permitted under law. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

I may use and release information about you to ensure that the services and benefits provided to you are appropriate and are high quality. For example, I may use your information to evaluate my treatment and service programs or to evaluate the services of other providers.

Unless you provide me with alternative instructions, I may contact you about reminders for treatment, medical care, or health check-ups. I may also contact you to tell you about health related benefits or services that may be of interest to you or to give you information about your health care choices.

I will disclose health information about you when required to do so by federal, state, or local law or in response to a court order, subpoena, warrant, summons, or other similar process.

I will notify the appropriate government authority if I believe you have been the victim of abuse, neglect or domestic violence. I will only make this disclosure if you agree or when required or authorized by law.

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In signing below I am verifying that I have received from Keith Jordan, LCSW a document containing a Notice of Mental Health Privacy Practices/HIPAA Requirements.

Signature: _____

Print Name: _____

Date Signed: _____