Rosamond Therapeutic Services, LLC
Ida Seiferd LCSW
831 Royal Gorge Blvd Ste 226
Canon City, CO 81212
Phone: 303-801-8366

CLIENT REGISTRATION

Client's Full Name: _____ Date of Birth: _____
SSN #: _____ Gender: M___ F___ Other:_____
Is the client a minor (under age 18) child? YES___NO ___ Custodial Parent's Name: _____
Street Address: _____ Home Phone:_____
City, State, Zip: _____ Cell Phone: _____
E-mail: _____ (optional)
Marital Status: Married ____ Never Married ____ Domestic Partnership ____ Separated ____ Divorced ____ Widowed ___
Client's Occupation: _____ Employer: _____
Work Phone: _____ Student/ School: _____

EMERGENCY CONTACT INFORMATION
Name: _____ Relationship: _____
Phone #s: _____

PRIMARY CARE PHYSICIAN _____ Phone #: _____

PRIMARY INSURANCE Name: _____ Phone #: _____
Name of Insured: _____ SSN #: _____
DOB: _____ ID # _____ Group # _____
Address: _____
Employer: _____ Work Phone: _____
Relationship to Client: _____

SECONDARY INSURANCE Name: _____ Phone #: _____
Name of Insured: _____ SSN #: _____
DOB: _____ ID # _____ Group # _____
Address: _____
Employer: _____ Work Phone: _____
Relationship to Client: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR/Insurance Holder) INFORMATION If same as client, please complete only Questions #1 and #3 of this section
1. Guarantor Name: _____ DOB: _____
2. Address: _____Phone #: _____
3. Driver's License #/ State: _____SSN#: _____
4. Guarantor's Relationship to Client: ___ Spouse ___ Mother ___ Father ___ Sibling ___ Relative/Friend ___ Legal Guardian ___
Other: _____
5. Guarantor's Employer _____ Work Phone# : _____
Occupation: _____

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Please read carefully and sign to attest to your agreement:
ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to: Ida Seiferd LCSW/Rosamond Therapeutic Services, LLC the amount due for services rendered to my dependent and/or me.
RELEASE OF INFORMATION: I authorize the release of any medical, behavioral health and/or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. This consent may be revoked at any time in writing, except where action has already been taken on the basis of this release. This release will expire automatically six months after the final payment has been received in my account. This Release is subject to State and Federal confidentiality requirements.
GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for all services rendered by provider Ida Seiferd LCSW/Rosamond Therapeutic Services, LLC. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, deductible and any non-covered services as identified in the disclosure statement. CLIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize Ida Seiferd LCSW/Rosamond Therapeutic Services, LLC to release information to my Guarantor or a Third Party Collection Agency (for outstanding balances after 60 days, with collection charges added).

_____

Client/Parent/Legal Guardian/Guarantor / Signature (Circle what applies)

CONSENT TO TREAT

Client Full Name: _____Date: _____ DOB: _____
I consent to the outpatient mental health evaluation and treatment recommended by Ida Seiferd LCSW/Rosamond Therapeutic Services, LLC I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

FEE AGREEMENT (Please read and initial all)

____ As a self-pay client, I agree to be responsible for payment at the time of each assessment/therapy session in the amount of _____. I become a self-pay client when my insurance becomes inactive.
____ I have _____ insurance and agree to be responsible for my co-payment, coinsurance and/or deductible (if applicable) and pay it at the time of each intake/therapy session in the amount of _____.
____ I agree to pay a case management fee of $35 for all non-routine phone calls, emails, or letters/reports written on my behalf to an authorized third party. I understand that these fees will be billed directly to me, not my insurance company.
____ I agree that if my check does not clear the bank I will be responsible for an additional fee of $25.
____ I agree to be responsible for payment of the full fee of $_____ for any missed appointments or appointments cancelled with less than 24 hours advance notice (except for documented emergency situations). I give permission for my credit card on file to be charged the day of the no show/cancellation without 24 hour advance notice.
Credit Card Number _____ _____ _____ _____ Exp. Date ___/____ Auth. Code_____ Billing Zip Code_____
____ I give my permission for outstanding balances to be reported to a collection agency after 60 days, with collection charges added. I understand that these fees will be billed directly to me, not my insurance company.

_____ Date: _____
Client/Legal Guardian/Guarantor Signature (Circle what applies)

_____ Date: _____
Ida Seiferd LCSW/Rosamond Therapeutic Services, LLC

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If client is a MINOR, please complete this section. Fill in all that applies.
Birth Mother's Name: _____
Step Father's Name: _____
Birth Father's Name: _____
Step Mother's Name: _____
Who brought minor child for counseling?

_____
Who is the legal guardian for the minor client?

_____
What is your relationship to minor client if none of the above? _____
If a divorce or a temporary order determines physical and legal custody, medical decision making power of attorney etc., please provide a copy of it as soon as possible, particularly if one parent is sole conservator. If applicable, who is the sole conservator?

_____
Please list all members of your household: Relationship/Age/ Gender
1. _____
2. _____
3. _____
4. _____
5. _____
Family Members to be involved in treatment: _____

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Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. Thank you!

Name_____ DOB:_____Date_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____
What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist:

( ) Depressed mood	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety/panic attacks**
( ) Change in sleep	**( ) Increased risky behavior**	**( ) Avoidance** *of reminders of trauma*
( ) Loss of interest	**( ) Increased irritability/anger**	**( ) Hypervigilance**
( ) Concentration/forgetfulness	**( ) Decreased need for sleep**	**( ) Nightmares/flashbacks**
( ) Change in appetite	**( ) Excessive energy**	**( ) Other**_____
( ) Excessive guilt	**( ) Sudden mood swings**	**( )** _____
( ) Fatigue	**( ) Enuresis/encopresis**	**( )** _____
( ) Hopelessness	**( ) Hallucinations/Delusions**	**( )** _____
( ) Crying spells	**( ) Suspiciousness/paranoia**	
( ) Isolation	**( ) Interpersonal problems**	

explain_____
_____
_____
_____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available?_____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself?_____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

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Primary Care Physician_____Phone_____
Do you give permission for me to discuss your treatment with your primary care physician? _____

Medical History:
Allergies_____
List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date-

_____
_____
Current over-the-counter medications or supplements: _____
Current medical problems: _____
_____
Past medical problems, non-psychiatric hospitalization, or surgeries:
_____
Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:
_____
_____
When your mother was pregnant with you, were there any complications during the pregnancy or birth? Did she use drugs or alcohol or experience domestic violence/trauma while pregnant?
_____
_____

Past Mental Health/Psychiatric History:
Outpatient treatment ( ) Yes ( ) No
Reason Dates Treated By Whom
_____
_____
Psychiatric Hospitalization ( ) Yes ( ) No
Reason Date Hospitalized Where
_____
_____
_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were
Name Dates Dosage Response/Side-Effects
Antidepressants_____
Mood Stabilizers_____
Antipsychotics/Mood Stabilizers _____
Sedative/Hypnotics_____
ADHD medications_____
Anti-anxiety medications_____

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Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No
Anger ( ) Yes ( ) No
Suicide ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No
Post-traumatic stress ( ) Yes ( ) No
Alcohol abuse ( ) Yes ( ) No
Other substance abuse ( ) Yes ( ) No
Violence ( ) Yes ( ) No

If yes, who had each problem? _____
_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?
_____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
_____

Check if you have ever tried the following:

Yes No If yes, how long and when did you last use?
( ) Methamphetamine
( ) Cocaine
( ) Stimulants
( ) Heroin ( ) Methadone
( ) Hallucinogens (LSD/mushrooms/peyote/other)
( ) Marijuana
( ) Pain killers (not as prescribed)
( ) Alcohol
( ) Ecstasy
( ) Other _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Trauma History:

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Do you have a history of being abused (emotionally, sexually, physically) or neglect? ( ) Yes ( ) No.
Please describe when and by whom:

_____
_____
_____
_____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No
Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation?
_____
What was your mother's occupation?
_____
Did your parents' divorce? ( ) Yes ( ) No How old were you when they divorced?_____ _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him:
_____
_____
Describe your mother and your relationship with her:
_____
_____
How old were you when you left home?
_____
Has anyone in your immediate family died? Who and when?
_____
_____

Educational History:
Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____Income $_____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

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Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) other ( ) prefer not to answer
Describe your relationship with your spouse or significant other:
_____
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender:_____
_____
Describe your relationship with your children:_____
List everyone who currently lives with you: _____
_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Legal History:
Have you ever been arrested? ( ) Yes ( ) No If yes, for what and when?
_____
Do you have any pending legal problems? _____

Is there anything else that you would like me to know?
_____
_____
_____
_____
_____

Signature_____Date_____
Guardian Signature (if under age 18) _____ Date _____
Emergency Contact _____Telephone # _____