NorthLakes
COMMUNITY CLINIC

888.834.4551
nlccwi.org

# Adult Mental Health Intake Form

***For Individuals Ages 18 and up***

| | |
|---|---|
| **Legal name:** | **Preferred Name:** |
| **Gender Assigned at Birth:** | |
| **Pronouns:** she/hers he/his they/them ze/zer ask me | |
| **For what issues are you seeking help?** | |
| | |
| **When did these issues start?** | |
| | |
| **What do you hope to gain from treatment? What would be a great outcome?** | |
| | |
| **How long do you expect to be in treatment?**<br>□ 1-3 sessions □ 4-10 sessions □ A long time □ No idea | |
| Education Level: | □ Pre-high school □ Some high school □ High school diploma □ Technical degree<br>□ College degree □ Other training: _____ |
| Current level of employment: | □ Part-time □ Full-time □ Unemployed □ Disabled □ Retired |
| What kind of work have you done? | |
| Have you ever served in the military? | □ Yes □ No |
| Do you have any other concerns? | □ Housing □ Food □ Transportation □ Childcare □ Other<br>□ Medical □ Dental □ Legal □ Other |
| Is spirituality an important part of your life? □ Yes □ No □ It's complicated<br><br>Have hobbies? □ Yes □ No What do you like to do for fun? | |

| CURRENT SYMPTOMS CHECKLIST | | | |
|---|---|---|---|
| *Please check the appropriate box for symptoms you have experienced in the past 2 weeks.* | **Daily √** | **Some √** | **None √** |
| Sadness/Depressed Mood | | | |
| Difficulty falling asleep | | | |
| Waking up early/during the night | | | |
| Increased need for sleep | | | |
| Feelings of guilt | | | |
| Low self-esteem | | | |
| Feelings of hopelessness | | | |
| Feelings of helplessness | | | |
| Fatigue/Low Energy | | | |
| Hard to concentrate | | | |
| Hard to make decisions | | | |
| Appetite increase or decrease | | | |
| Weight increase or decrease | | | |
| Crying spells | | | |
| Suicidal thoughts | | | |
| Attempts to harm self or "cutting" | | | |
| Isolating behaviors | | | |
| Difficulty in relationships | | | |
| Mood swings | | | |
| Increased energy | | | |
| Racing thoughts | | | |
| Increased spending | | | |
| Decreased need for sleep | | | |
| Feeling anxious | | | |
| Feeling "on edge" | | | |
| Panic Attacks | | | |
| Trembling or Shakiness | | | |
| Restlessness | | | |
| Irritability or Anger | | | |
| Shortness of Breath | | | |
| Forgetfulness | | | |
| Distractibility | | | |
| Impulsivity | | | |
| Nightmares | | | |
| Hearing or seeing things - others don't see/hear | | | |

| Strengths Checklist | | | |
|---|---|---|---|
| *Please check all that apply:* | √ | | √ |
| Ambitious | | Trustworthy | |
| Authentic | | Good Communicator | |
| Caring | | Leader | |
| Creative | | Problem Solver | |
| Dedicated | | Good Listener | |
| Enthusiastic | | Planner | |
| Flexible | | Detail Oriented | |
| Honest | | Understanding | |
| Logical | | Passionate | |
| Motivated | | Healthy | |
| Optimistic | | Strong | |
| Open-Minded | | Confident | |
| Persistent | | Resilient | |
| Responsible | | Other | |

| Self/Family Mental Health History | | | | | | |
|---|---|---|---|---|---|---|
| Please check all that apply. | Self | Mother | Father | Grandparent | Sibling | Other |
| Bi-Polar | | | | | | |
| Schizophrenia | | | | | | |
| Depression | | | | | | |
| Anxiety | | | | | | |
| Post-traumatic stress | | | | | | |
| Drug or alcohol addiction | | | | | | |
| Eating disorder | | | | | | |
| Anger issues | | | | | | |
| Violence | | | | | | |
| Suicide | | | | | | |
| Attention/Focus issues | | | | | | |
| Other | | | | | | |

| Family/Childhood Relationships | | |
|---|---|---|
| **Do any of the following words describe your family life while growing up?** | | |
| □ Close | □ Distant | □ Frightening |
| □ Stable | □ Unstable | □ Angry |
| □ Poor | □ Rigid | □ Supportive |
| □ Abusive | □ Warm | □ Cold |
| □ Other: | | |

## Past mental health or substance abuse treatment

| Reason | When | Where & Did you Successfully Complete? |
|---|---|---|
| | | □ Yes □ No |
| | | □ Yes □ No |
| | | □ Yes □ No |

Are you in Recovery? □ Yes □ No If Yes, for how long?_____

Do you have a Primary Care Physician? □ Yes □ No Name:

Do you have a Dentist? □ Yes □ No Name:

Are you taking any medications or supplements? □ Yes □ No

What are they?

How often do you drink caffeinated beverages/energy drinks? ☐ a little □ a lot □ never

Have you ever had a head injury or concussion? (if yes, explain) □ Yes □ No

| **Please check ONE box for each question.** | **Never** | **1-2 days** | **3 or more days** |
|---|---|---|---|
| **In the past month**, on how many days did you use tobacco? | | | |
| **In the past month** on how many days did you have 4 or more alcoholic drinks in a day (including wine or beer)? | | | |
| **In the past month** on how many days did you use any illegal drug (including marijuana)? | | | |
| **In the past month**, on how many days did you use any prescription medications recreationally (just for the feeling or using more than prescribed)? | | | |

**Do you or anyone else have any questions or concerns about your drug or alcohol use? ☐ Yes □ No**

## Relationships

Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

For how long?

Describe your relationship with your significant other:

Do you have children? How many? Ages? Are they with you? □ Yes □ No

Do you have any close friends or family members who are helpful or supportive? □ Yes □ No

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**OUTPATIENT MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES**
**WELCOME LETTER**

Welcome to our clinic! We understand that the amount of paperwork presented for review and signatures during the first visit can be overwhelming. We urge you to let us know if you need a break or if you have any questions as the required paperwork is completed. Thank you for your patience.

**Forms**

Attached you will find several items for your review. You may keep the following documents for your records:

- HIPAA Notice of Privacy Practices
- Brochure – "Client Rights and the Grievance Procedure" or "Rights of Children and Adolescents"
  -This includes information about filing a grievance

Upon completion of your paperwork, you may ask for a copy of your signed:

- Informed Consent
- Clients Rights Policy

**Contact numbers**

You may call the clinic at: 888-834-4551 to make an appointment. **NorthLakes Community Clinic does not provide emergency behavioral health care. Always, in the case of an emergency, dial 911. If you are having a crisis after hours call the Mental Health Crisis line at 1-866-317-9362 or the National Suicide Prevention Lifeline at 1-800-273-8255 or go to your local emergency room.**

General clinic hours of services are Monday through Friday from 8:00 a.m. to 5 p.m.

**Discharge**

As determined by you and your therapist, you will be discharged upon completion of your treatment program.

There are circumstances under which you may be involuntarily discharged. The following are possible reasons for an involuntary discharge:

- referral to another treatment resource is deemed necessary by your provider
- excessive missed appointments

**I have read and understand the above, have had an opportunity to ask questions about this information. I understand that I have the right to ask questions of my treatment provider about the above information at any time.**

_____ _____

**Signature of client ages 18 years or older or legal representative** **Date**

_____ _____

**Witness** **Date**

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## INFORMED CONSENT

Patient Name: _____ DOB: _____

I understand that I am seeking services regarding a health problem or suspected health problem at NorthLakes Community Clinic (NorthLakes) to be provided by authorized employees of the Clinic, etc. I consent to routine services, which may include but are not limited to: assessment, evaluation, diagnosis, treatment planning, therapy, group therapy, education, discharge planning, referral, and follow up care. These program elements have been explained to me and I understand what the services are. I understand I can withdraw this consent at any time, and that **it is effective for one year from this date**.

**In addition to the above be informed that:**

- Benefits that will come from this treatment could include a solution to your presenting problem, better coping skills or a better adjustment to your life situation.
- You and your provider will establish the treatment plan that will include how often you will meet with the provider and who may be included in your treatment.
- The clinician providing treatment is not credentialed by OptumHealth/UBH and the visits will be billed under their supervising provider.
- Treatment does not always result in positive changes. Occasionally the problems remain despite your and your provider's best efforts. In some cases, new problems may arise or unwanted changes occur. For example, talking about your depression may make you feel worse initially, or as you get better, other problems arise and become important.
- Besides the proposed ways of addressing your problems, there are other resources such as self help groups, spiritual teachers, cultural activities, church or other support groups or providers with different approaches.
- If you elect not to seek treatment a number of things could happen. Your problems may solve themselves, your problems may remain as they are, your problems may worsen, or new problems may appear.
- Information shared in sessions is confidential and will not be released without specific written authorization from you or your representative. For the purpose of continuity of care, information can be shared with other providers within the NorthLakes Clinic who are also involved in your treatment. This confidentiality remains after termination and we maintain records for seven years.

**Information that cannot be kept confidential that your provider and NorthLakes Community Clinic is required by law to release includes:**

- Suspected or actual physical and/or sexual abuse or neglect of a child or vulnerable adult
- Information requested in a court order
- Situation in which you are judged to be in imminent or immediate danger of harming self or others.

**NorthLakes Clinic does not provide emergency behavioral health care. In case of an emergency, please contact your local emergency room or call the Crisis Hotline at (866) 317-9362.**
Our general hours of service are 9:00AM-5:00PM.

By my signature below, I give consent for the administration of the above described treatment. I have been given complete and accurate knowledge, and I understand that no promises have been given to me as to the results of the treatment.

**X**_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Signature of Provider Date

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# CLIENT RIGHTS POLICY

Patient Name: _____ DOB: _____

## Clients have the following rights under Wisconsin state law:

- The right to be informed of your rights as a patient/client. 51.61(1)(a)
- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status. 51.90
- The right to the least restrictive treatment conditions necessary. 51.61(1)(e)
- The right to receive prompt and adequate treatment. 51.61(1)(f)
- The right to be informed of your treatment and care and to participate in the planning of your treatment and care. 51.61(1)(fm)
- The right to be free from any unnecessary or excessive medications at any time. 51.61(1)(h)
- The right to refuse all medication and treatment unless court-ordered or unless medication and/or treatment is necessary to prevent serious physical harm to the yourself or to others. 51.61(1)(g)
- The right to a humane psychological and physical environment. 51.61(1)(m)
- The right not to be subjected to experimental research without your informed, written consent. 51.61(1)(j)
- The right not to be subjected to psychosurgery or other drastic treatment procedures without your written, informed consent. 51.61(1)(k)
- The right to petition the court for review of your commitment order. 51.61(1)(d)
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of section 51.30. 51.61(1)(n)
- The right not to be filmed or taped without your permission. 51.61(1)(o)
- Be informed about the costs of treatment and medications. 51.61(1)(w)
- The right to file a grievance about violation of these rights without fear of retribution. 51.61(1)(u)
- The right to go to court if you believe that your rights were violated. 51.61(7)(a)
- Have the right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact. 51.61(1)(x)

By my signature below, I acknowledge that I received or was offered a copy of the Clients Rights.

X_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature/Initials of NorthLakes Staff Date

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## ATTENDANCE POLICY

Date: _____

Client Name: _____ DOB: _____

Therapy will not be effective unless it is consistent and regular. Therefore, regular attendance at all appointments is important.

**CANCELLATIONS – NON EMERGENCY:**

Except for emergency situations, all appointments are to be cancelled at least 24 hours in advance by calling or cancelling in person. We consider the following to be examples of NON EMERGENCY reasons to cancel an appointment: vacations, prescheduled doctor appointments, family events, parties, recreational events, after school activities, lack of baby sitter, holiday weekend, school holiday, day before or after a holiday, schedule conflict, and sibling illness. **Initial** _____

**CANCELLATIONS – EMERGENCY:**

In case of emergency (sudden illness, death in family, hospitalization, emergency doctor visit), appointment must be cancelled as early as possible prior to appointment time. **Initial** _____

**CLOSINGS DUE TO WEATHER:**

If NorthLakes Community Clinic decides to close the office due to poor weather, we will contact you. We do not necessarily close because school is closed. If we are open, and you decide to cancel due to weather conditions, we ask that you do so at least 2 hours before your scheduled appointment. **Initial** _____

**ATTENDANCE:**

If two appointments are missed and/or cancelled with less than 24 hours due to a non-emergency you and I will have to discuss whether or not to continue working together. A third such event within a two month period may lead to termination of your behavioral health treatment at NorthLakes Community Clinic. **Initial** _____

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS.

**X**_____ _____

Client Signature Date

**X**_____ _____

Parent/Guardian Signature Date

**X**_____ _____

Therapist Signature Date

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# SERVICE FEES

**Fees associated with our counseling services**

This table shows session fees for Behavioral Health Services with a Behavioral Health Counselor.
These fees exclude any Pyschiatriac Nurse Practioner Testing
Insurance benefits vary, please call your insurance for coverage questions.

## BEHAVIORAL HEALTH COUNSELING FEES

| | |
|---|---|
| Initial and Updated Evaluations | $205.00 |
| Individual- 30 minute Session | $140.00 |
| Individual- 45 minutes Session | $160.00 |
| Individual- 60 minutes Session | $215.00 |
| Family without Client Session | $115.00 |
| Family with Client Session | $156.00 |
| Group Session | $125.00 |
| Couples Therapy<br>Please check with your insurance about Couple's Therapy coverage | $156.00 |

## QUALIFYING- BEHAVIORAL HEALTH SLIDING FEE SCALE FEES

| | |
|---|---|
| Slide A | $ 0.00 |
| Slide B | $10.00 |
| Slide C | $15.00 |
| Slide D | $20.00 |
| Slide E | $25.00 |

## TESTING FEES

| | |
|---|---|
| OWI Assessment- Ashland County Resident | $200.00 |
| OWI Assessment- Bayfield County Resident | $200.00 |
| Psychological/Neuropsychological Testing | $297.00 first 60 minutes and $226.00 for each additional 60 minutes |
| Psychological/Neuropsychological Battery of Tests | $120.00 first 30 minutes and $111.00 for each additional 30 minutes |

I verify that I have been shown the fees for Behavioral Health Services.

Client Signature:_____ Date:_____

Parent/Guardian:_____ Date: _____

Witness Signature:_____ Date: _____