CLIENT INFORMATION

Date______________ Chart #____________________

Last Name_____________________________________ First Name______________________________ MI_______

Address____ Telephone #: ____________________________

City____ State_______ Zip_________County: ___________________

E-mail: ____

Does JFS have your permission to e-mail appointment confirmations?___Yes/No_______Initials: ___________________

Birth date_____/______/______ Age_______ Gender __F __M SSN: ______________________________

Emergency Contact Name: _____________________________________Telephone #: ___________________________

Assistance Requested: ☐ Emergency Services ☐ Counseling

Have you received services from JFS in the past? ☐ Yes ☐ No If yes, type of assistance: ______________________

Housing: ☐ Apartment ☐ Hotel/Motel ☐ Mobile Home ☐ Single Family Dwelling ☐ Unknown

Address Type: ☐ Rent ☐ Own ☐ Shelter ☐ Family/Friend ☐ Homeless

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Living Together

☐ Minor: Name of Parent/Legal Guardian(s): ____

The following information is collected for demographic purposes only:

Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Multi-racial ☐ Other: ___________________________

Religion: ☐ Jewish ☐ Other: ____

Spouse/Partner's Name: ______________________________________ SSN: ________________________________

List the family members/people who live with you: *(additional lines on the back of this form)*

Name	Age	Relationship

How did you hear about us? *(please check all that apply)*

☐ 211 Community Resources ☐ Physician ☐ School ☐ Family/Friend ☐ Church/Synagogue

☐ Second Harvest ☐ Website ☐ Other Agency: ____

CLIENT INFORMATION, continued

Date______________ Chart #____________________

Last Name______________________________________ First Name______________________________ MI_______

Please check total monthly income and fill in source(s) of income:

☐ $0- $1,250 ☐ $1,251- $2,083 ☐ $2,084- $4,166 ☐ $4,167- $6,250 ☐ $6,251 and above

☐ Social Security $________ ☐ Food Stamps $________ ☐ SSI $_________

☐ Unemployment $________ ☐ Child Support $________ ☐ Pension $_________ _☐ Other $_________

☐ Wages $________ ☐ FT Employment ☐ PT Employment

Insurance Information

Primary Insurance________________________________

Phone____

Contract/ID#____________________________________

Group/Acct#____________________________________

Subscriber______________________________________

Subscriber Date of Birth __________________________

Client's relationship to Subscriber

__Self __Spouse __Child __Other_______________

Secondary Insurance________________________________

Phone____

Contract/ID#____________________________________

Group/Acct#____________________________________

Subscriber______________________________________

Subscriber Date of Birth__________________________

Client's relationship to Subscriber

__Self __Spouse __Child __Other_______________

Do we have your permission to verify your insurance benefits? ☐ Yes ☐ No ________Initials ☐ Verbal consent by phone

I certify that the above information is true and accurate.

Client Signature: ____ **Date:** __________________________________

Data entered ___/____/____ by ________________________

Rev: 5/17

INFORMED CONSENT TO TREATMENT

Client Name:____ **Chart #**_____________________

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with Jewish Family Services of Greater Orlando., hereby referred as JFS. The rights, risks and benefits associated with the treatment have been explained to me. A qualified clinician will provide the agreed upon clinical services. I understand that JFS does employ licensed counselors as well as unlicensed counselors and interns that work under the supervision of a licensed clinician. I understand that if I am not comfortable with the qualifications of my clinician, it is my responsibility to request a re-assignment from the JFS's director or CEO.

I understand that the therapy may be discontinued at any time by either party. JFS encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. A client may be terminated from therapy non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Center, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner, and/or C) the client does not attend or schedule an appointment for 90 days. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with JFS or request to re-apply for services at a later date.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the JFS Office(s), against any person who works for the Center, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the JFS duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. Client records may be reviewed by managed care organizations including your own managed care organization, as well as the Agency for Health Care Administration, and/or its representatives.

I consent to treatment and agree to abide by the above stated policies and agreements with Jewish Family Services of Greater Orlando

____ _______________
Signature of Client Date

____ _______________
Signature of Legal Guardian *if applicable* Date

Fee Policy & Agreement

Client Name: ___________________________________ **Client Chart #:**____________________

We welcome you to our Agency and hope you will find our services helpful. Jewish Family Services is a private non-profit organization providing social services to the community. We are supported by client fees.

The cost for Jewish Family Services to provide one hour (1) of counseling services or case management is $120.00. Thus, there is an hourly based fee for any service we provide to you or your family through or home visits. Client fees are an important source of income to JFS and as it is how we pay our counselors.

I agree to the following payment for counseling services:

Per counseling or case management hours, the full agency fee, without insurance coverage or hardship waiver, is $120.00 per hour.

I agree to be responsible for: [ ]$________ co-pay or [ ]$_________ hardship waiver, per session.

I understand that my appointment time is reserved **exclusively** for me and/or my dependent. Consequently, if I fail to keep my appointment without providing **24 hours notice, I will be charged**, my agreed upon fee of **$40.00** for the appointment. I will pay by **cash, check or be charged to my credit card the above amount.**

Credit Card Type:_____________**Credit Card #:**____ **Exp.Date**_____________

CVV______________

If there is any change in my financial condition that might alter the agreement, I will bring it to the attention of my therapist, case manager or coordinator. I agree that charges incurred by me and/or members of my family will be paid in full before my next session. I understand Jewish Family Services reserves the right to alter its fee structure.

For Insurance clients: I authorize the release of any information necessary to process this claim and related claims. I request that payment of authorized benefits be made to Jewish Family Services for any services provided to me by this Agency.

I had the opportunity to ask any questions to help me understand this policy and agreement. I understand and will abide by this policy and agreement.

____ ____________________________

Client or Responsible Party Signature Date

____ ____________________________

Client Name (Print) Therapist Signature

Privacy Practices Acknowledgement

My signature below certifies that I have read or have had the opportunity to read the Notice of Privacy Practices that is posted in the Jewish Family Services office. I understand that I may obtain a printed copy of the Notice at any time from any staff member at the Jewish Family Services of Greater Orlando office. I further certify that any questions I have related to the Notice have been answered.

____ ____________________________

Client or Responsible Party Signature Date

Client Rights Acknowledgement

My signature below certifies that I have read or have had the opportunity to read the Client Rights information that is posted in the Jewish Family Services office. I understand that I may obtain a printed copy of my Rights at any time from any staff member at the Jewish Family Services of Greater Orlando office. I further certify that any questions I have related to the Rights have been answered.

____ ____________________________

Client or Responsible Party Signature Date

ALERT® **Wellness Assessment - Adult**

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name ____ , First Name ____ Date of Birth (mm/dd/yy) __/__/__

Subscriber ID ____ Authorization # ____

Clinician Last Name ____ , First Name ____ Today's Date: (mm/dd/yy) __/__/__

Clinician ID/Tax ID ____ Clinician Phone ____ - ____ State ____ *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ____ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ____ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ____ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

Reviewed and discussed: Clinician Initials:________ Date: _____________

ADULT HISTORY FORM

Name: ______________________________ **DOB:** _________ **Age:** __________ **Date:** ________

PRESENTING PROBLEM:
Describe the problems you are having and when they began:

SYMPTOM CHECKLIST:
Please check any symptoms you are experiencing.

___ Aggression/Anger Outbursts
___ Alcohol Abuse
___ Anxiety
___ Avoidance of People
___ Chest Pains
___ Computer Addiction
___ Depression
___ Difficulty Concentrating
___ Difficulty Thinking
___ Distractibility
___ Dizziness
___ Drug Abuse
___ Eating Disorders
___ Elevated Mood
___ Fatigue
___ Fears: (List)
____
___ Gambling
___ Hallucinations
___ Headaches
___ Helplessness
___ Hopelessness
___ Impulsivity
___ Indecisiveness
___ Irritability
___ Loneliness
___ Memory Problems
___ Mood Swings
___ Muscle Tension
___ Panic Attacks
___ Racing Thoughts
___ Restlessness/On Edge
___ Sexual Addiction
___ Sexual Difficulties
___ Sleeping Problems
___ Stress
___ Suicidal Thoughts
___ Trembling
___ Weight Gain/Less
___ Withdrawal
___ Worrying
___ Worthlessness
___ Other Symptoms
____
____
____
____
____

PAST HISTORY OF MENTAL HEALTH PROBLEMS/TREATMENT:
Include therapy, hospitalizations, medications and your impression of their effectiveness and utilization of community resources

PAST HISTORY OF ABUSE:
Include by whom and at what age physical, emotional, sexual or neglect occurred

FAMILY HISTORY OF MENTAL HEALTH AND/OR SUBSTANCE ABUSE PROBLEMS:
Include diagnoses, treatment, and the individual's relationship to you

CURRENT STRESSORS:
Please check all that apply.

___ Marital Conflict	___ Poor Peer Relations	___ Legal Problems	___ Victim of Abuse
___ Separation/Divorce	___ Problems at Work	___ Health Problems	___ Physical
___ Conflict with Children	___ Job Loss or Change	___ Recent Death	___ Emotional
___ Conflict with Parents	___ Problems at School	___ Substance Abuse Problems	___ Sexual
___ Conflict with Siblings	___ Recent Move	___ Housing Problems	
___ Conflict with Other Family	___ Financial Problems	___ Other (List): ______________	

SUBSTANCE USE:
Please indicate both current and past use.

Substance	Current Use Yes	Current Use No	Past Use Yes	Past Use No	Amount Used	Frequency	Date Last Used
Tobacco	___	___	___	___	________	________	________
Caffeine	___	___	___	___	________	________	________
Alcohol	___	___	___	___	________	________	________
Marijuana	___	___	___	___	________	________	________
Cocaine/Crack	___	___	___	___	________	________	________
Heroin	___	___	___	___	________	________	________
Amphetamines	___	___	___	___	________	________	________
LSD	___	___	___	___	________	________	________
Ecstasy	___	___	___	___	________	________	________
Inhalants	___	___	___	___	________	________	________
IV Drug Use	___	___	___	___	________	________	________
Prescription Drugs	___	___	___	___	________	________	________

(Include Names of Prescription Drugs below and indicate if they were prescribed for you)

ADDITIONAL COMMENTS:

List any use of herbal supplements or misuse of over the counter medications:

PAST HISTORY OF SUBSTANCE ABUSE TREATMENT:
Include AA/NA, counseling, hospitalization, and residential care.

HISTORY OF LEGAL PROBLEMS:
Include any current charges, pending court dates, history of arrests, probation, child custody and divorce issues, or guardianship issues.

Patient Name: ______________________

MEDICAL HISTORY:

Do you have a Primary Care Physician (PCP)? ___Yes ___ No

Name of PCP: ___________________________________ Phone #: _________________ □ No PCP

Date of last visit: ___________________________________ Date of last physical: _________________

May we communicate with your PCP? □ Yes □ No □ N/A

Do you now have or have you ever had any of the following medical problems:

___ Head Injury
___ Heart Disease
___ Hepatitis
___ Hypoglycemia
___ Asthma
___ High Fevers
___ Other ___________________________________

___ Seizures
___ Lung Disease
___ TB
___ Diabetes
___ Arthritis
___ Meningitis

___ Thyroid Problems
___ Liver Disease
___ HIV
___ Cancer
___ Chronic Pain
___ Loss of Consciousness

___ Hypertension
___ Kidney Disease
___ Sexually Transmitted Diseases
___ Memory Problems
___ Headaches
___ Other _______________

Describe any checked items above, including age of onset:

List any hospitalizations/surgeries:

Current Medications, including who prescribes them and what they are prescribed for:

Medication	Dosage	Date Started	Prescribed by	Condition prescribed for

List any Allergies:

Family History of Medical Problems:

Patient Name: ___________________________

SOCIAL HISTORY:

Place of Birth: ____________________ Where did you grow up? ________________________________

Did your family move around? If yes, please describe:

How many siblings do you have?

Which family members are you close to?

Describe your childhood:

Were you ever physically, sexually, or emotionally abused?

Who do you rely on for emotional support?

Have there been significant losses, changes or crises in your life? If yes, please describe.

Do you have any type of **belief system** (moral, spiritual, cultural, religious) that influences your life?

EDUCATIONAL HISTORY:

What is the highest grade you completed?

Did you receive any special education services?

How did you get along with your teachers and your peers?

Did you have any discipline problems at school?

Patient Name: __________________________

MILITARY HISTORY:

Did you or do you serve in the military? ___Yes ___No   What branch and dates of service? ________________

Were you stationed in a combat or other high-risk zone?

Type of discharge:

OCCUPATIONAL HISTORY:

Are you currently employed? ___ Yes ___ No

Where do you work? ______________________ How long have you worked there? __________________

What is your current position? ______________________ Do you like your job? ___ Yes ___ No

Are there any current job stressors you are experiencing?

Do you get along with your co-workers?

RELATIONSHIP HISTORY:

What is your sexual orientation?

What is your marital status? ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated __ Other

Describe your current relationship, including any problems:

Describe any prior marriages or long-term relationships and the reason for the divorce/break up:

List the names and ages of any children you have had, including any who are deceased:

Describe any problems you are currently experiencing with your children?

List all people currently residing in your home:

Patient Name: ____________________________

RISK ASSESSMENT:

	Past	Now
Have you ever had thoughts of hurting yourself?	___	___
Have you ever had thoughts of committing suicide?	___	___
Have you ever had a plan to commit suicide?	___	___
Have you made threats to kill yourself?	___	___
Have you ever made a suicide attempt?	___	___
Have you ever mutilated yourself?	___	___
Have you ever had thoughts of harming someone?	___	___
Have you ever had plans to harm someone?	___	___
Have you ever attempted to harm someone?	___	___
Have you made threats to harm someone?	___	___

Is there any other information that would be helpful for your clinician to know?

Why are you seeking treatment now and what are are your expectations for treatment?

Are there any family members or significant others you would like to involve in your treatment?

______________________________________ ____________________

Your Signature Date

Patient Name: ______________________________

Reviewed and discussed: Clinician Initials:________ Date: _____________