Start and Associates

Psychological Support

Consent for Treatment

Psychological Support:
Our intent is to offer a calm place where you will feel accepted and understood. Thus, the relationship between you and your therapist is of upmost importance and if the fit does not seem right, please discuss with your therapist or Amy Goodman at 616.607.4476 or amy@startandassociates.com. We want you to feel settled and comfortable.

Contacting Your Therapist:
Your therapist can be contacted via his/her phone or email for scheduling and other matters. If your therapist is unable to respond and it is an emergency, please phone your physician or 911.

HIPAA/Confidentiality:
We adhere to ethical and legal guidelines regarding HIPAA and confidentially. Most everything is confidential under these guidelines though we must report to family members(s), hospital, and/or authorities: any abuse or neglect, or threat of abuse or neglect, to another person or animal; threat to harm or kill another person or animal; or threat to harm or kill oneself. There might be times when information is discussed with Dr. Toni Start, Licensed Psychologist and Owner, and/or the therapist's supervisor. Signing this form gives your therapist consent to do so.

Sessions and Fees:
Most sessions are approximately 50 minutes unless otherwise planned and will be scheduled directly with your therapist. We accept private pay and are in-network with most insurance companies. Private pay will be determined between you and your therapist before your first appointment. If you opt to use your health insurance, ***it is your responsibility to understand your specific benefits such as what costs you will accrue for deductibles and co-pays as well as how many sessions are covered.*** Your fees will be paid at session time or in some situations, we will bill you. If your balance exceeds your ability to pay at session time, a payment plan could be considered. ***We may charge a late cancellation (cancellation is within 24 hours) or no-show fee up to $150.00 per incident or the allowed amount per insurance reimbursement rates.*** Please note insurance companies do not provide reimbursement for these incidents.

All therapists here get compensated per session and are not salaried by the group. All therapists' time is valued and needed by many people; therefore, we respect and impose our late cancellation and no-show fee agreement.

Your signature below indicates you read, understood, and agree to the terms including the late cancellation and no-show fee agreement. Please ask your therapist any questions regarding this consent for treatment.

_____

Print Name of Client Date

_____

Client Signature

_____

Parent Signature if Client is a Minor

START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

Adult Intake Form: The intention of this form is to get to know you. If you are uncomfortable completing a portion(s) of this form, feel free to skip that area(s). Please complete this form to your comfort level. Thank you.

Name: _____ Date of Birth: _____
Address including street, city and zip code:
_____
Home phone: _____
Cell phone: _____
Work phone: _____
Email address: _____
How would you prefer to be contacted? _____
May your therapist contact you on your other numbers? _____
Emergency contact and phone number: _____
How did you hear about us? _____
May we send you a satisfaction survey via email? _____

Your Family of Origin
Names of parents/caregivers: _____
_____
_____

Please share pertinent information about your parents/caregivers such as their professions, locations, health, etc.: _____
_____
_____
_____

Siblings' names and ages: _____
_____

Please describe your relationships with your family members: _____
_____
_____
_____
_____

Your hometown: _____

Your Current Family
Partner's name: _____
Partner's address: _____
Partner's phone number: _____
Partner's profession: _____
Partner's health: _____
Children's names and ages: _____
_____
_____

What is your profession/place of employment? _____
_____

To your comfort level, please explain what brings you here - what issues/problems you would like to address:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When did these problems/issues begin? _____

Are you seeing any other therapists at this time? _____

What growth would you like to achieve while here?

_____
_____
_____
_____
_____
_____
_____

Your Lifestyle and Habits

Your support system: _____

Your ways of coping: _____

Your exercise habits: _____

How well do you sleep: _____

Your eating habits: _____

How many caffeinated beverages daily/weekly? _____

Alcohol Habits

How many alcoholic beverages do you drink daily/weekly? _____

What age did you begin drinking? _____

Are you and/or others concerned with your drinking habits? _____

Explain any legal trouble due to alcohol. _____

Smoking Habits

Do you smoke cigarettes? If so, how much daily/weekly? _____

Do you smoke marijuana? If so, how much daily/weekly? _____

Illegal Drugs Habits

If you engage in illegal drugs, which ones and how often?_____

_____

What age did you begin using illegal drugs? _____

Are you and/or others concerned with your illegal drug habits? _____

Explain any legal trouble due to illegal drugs. _____

If not currently drinking alcohol, smoking, and/or using drugs, have you in the past? If so, please explain.

_____

_____

_____

_____

Health Information

Physician's Name: _____

Please explain any medical problems you are currently being treated for:

_____

_____

List any prescription medications you are taking, amount, when you began taking them and reasons prescribed: _____

_____

_____

Please explain any concerns with medications: _____

_____

List any injuries, surgeries, or medical concerns you have had in the past:

_____

_____

Have you ever received inpatient psychological support in the past? If so, provide places, dates, and circumstances: _____

_____

_____

Please circle any that apply to you in the past or presently:

Anxiety	Social withdrawal	Distractibility
Depression	Irritability	Procrastination
Restless sleep	Food addictions	Nervousness
Suicidal thoughts	Sex addiction	Dislike self
Suicide attempts	Gambling/spending addiction	Chronic guilt
Illegal drug use	Relationship issues	Blackouts
Substance abuse	Communication issues	Memory loss
Caffeine addiction	Having many fears	High or low sex drive
Workaholism	Impulsivity	Anger
Perfectionism	Brain fog	Grief
Legal troubles	Panic attacks	OCD habits

Please circle any words that would describe you:

Happy	Confident	Trustworthy
Lonely	Helpless	Useless
Worthwhile	In control	Worthless
Healthy	Hopeless	Confused
Loveable	Overwhelmed	Feeling trapped
Open-minded	Unlovable	Hardworking
Successful	Spiritual	Religious
Guarded	Settled	A seeker
Bored	Scared	Moody
Grounded	Free spirit	Hopeful

Is there anything else you would like to share at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your disclosure. We hope to help you achieve the growth you hope for. Please sign below.

_____

Signature Date

Name: _____ Date: _____

Instructions: Read each statement carefully. Reflecting on the past week, including today, please indicate how you have been feeling. Mark the answer that best describes your current situation. For this questionnaire, "work" is defined as employment, school, housework, volunteer work, etc.

1. I have trouble falling asleep or staying asleep.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

2. I feel no interest in things.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

3. I feel stressed at work, school, or other daily activities.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

4. I blame myself for things.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

5. I am satisfied with my life.
   ○ 4 Never/almost never ○ 3 Rarely ○ 2 Sometimes ○ 1 Frequently ○ 0 Almost Always

6. I feel irritated.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

7. I have thoughts of ending my life.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

8. I feel weak.
   ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

9. I find my work, school, or other activities satisfying.
   ○ 4 Never/almost never ○ 3 Rarely ○ 2 Sometimes ○ 1 Frequently ○ 0 Almost Always

10. I feel fearful.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

11. I use alcohol or drugs to get going in the morning.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

12. I feel worthless.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

13. I am concerned about family troubles.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

14. I feel lonely.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

15. I have frequent arguments.
    ○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

16. I have difficulty concentrating.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

17. I feel hopeless about the future.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

18. I am a happy person.
○ 4 Never/almost never ○ 3 Rarely ○ 2 Sometimes ○ 1 Frequently ○ 0 Almost Always

19. Disturbing thoughts come into my mind that I cannot get rid of.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

20. People criticize my drinking or drug use.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

21. I have an upset stomach.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

22. I am not working or studying as well as I used to.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

23. I have trouble getting along with friends and close acquaintances.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

24. I have trouble at work/school because of drinking or drug use.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

25. I feel that something bad is going to happen.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

26. I feel nervous.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

27. I feel that I am not doing well at work/school.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

28. I feel something wrong with my mind.
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

29. I feel “blue.”
○ Never/almost never ○ Rarely ○ Sometimes ○ Frequently ○ Almost Always

30. I am satisfied with my relationships with others.
○ 4 Never/almost never ○ 3 Rarely ○ 2 Sometimes ○ 1 Frequently ○ 0 Almost Always

Please list reasons why seeking treatment: _____
_____

Regarding these reasons, rate your level of distress at this time:
No distress 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 A lot of distress

START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

Client Name: _____ Date of Birth: _____
Previous Name(s): _____
I request and authorize Start and Associates Psychological Support to release and/or obtain healthcare information of the person named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other _____

_____
Signature Date

_____
Parent/Guardian's Signature Date

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS REVOKED IN WRITING.