Mary Jean Padalino, LLC

Client Contact Information

Name____

Address (street & number)____

City_________________________________ State________Zip_____________

Birth Date_______ / _______ / _______ Age_____________

Gender (check one): _____Female _____Male _____Prefer not to disclose

Phone Number____________________________

Email____________________________________

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation____________________________________

Place of employment____

Emergency Contact Name_________________________ Relationship_____________

Emergency Contact's Phone number____

Mary Jean Padalino, LLC ~ 119 Maple Avenue, Red Bank, NJ 07701

Phone: 732-908-0025 ~ Email: mpadalino@live.com ~ www.MaryJeanPadalino.com

Mary Jean Padalino, LLC

Client Intake Form

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential and if there is a question, or questions, that you would prefer not to answer, please feel free to leave it blank and discuss it in session.

Name____**Date**_____________________

How were you referred to my office?____

Presenting Problem

1. What is the reason (or reasons) that you are seeking therapy today?

2. Did a specific event lead to you wanting to come to therapy? If yes, please describe the incident.

3. How long has the problem been present?

4. What areas of your life have been affected by this problem?

5. What solutions to the problem have you tried, and what were the results?

6. Please describe what you hope to accomplish in therapy or what you hope will be different in your life as a result of attending therapy.

7. Marital status, please check:

____ Single ____Married ____Separated ____Divorced ____Widowed

8. If you are currently in a romantic relationship, how would you describe the state of your relationship?

9. Please list any children, their names, and ages:

10. Please list any pets:

Symptoms

1. Are you currently experiencing overwhelming sadness, grief or depression?

2. Are you currently experiencing anxiety, panic attacks, or do you have any phobias?

3. Please describe any major losses or traumas that you have experienced:

4. Have you ever thought about, planned, or attempted suicide? If yes, when was this?

5. Do you have issues with anger or your temper?

6. Do you have overwhelming feelings of guilt?

7. Do you have overwhelming feelings of insecurity or inferiority?

8. Do you experience flashbacks or intrusive memories?

9. Do you have periods of high energy with less need to sleep?

Physical Health & Medical History

1. How would you rate your current physical health? Check one.

____Poor ____Unsatisfactory ____Satisfactory ____Good ____Excellent

2. List any significant health problems, past or present, including surgeries and/or illnesses.

3. Are you currently experiencing any chronic pain?

4. Are you experiencing a change in your sleeping patterns? If yes, please describe.

5. Are you experiencing a change in your weight or eating habits? If yes, please describe.

6. Do you have a history of restrictive eating, dieting, bingeing, and/or purging? If yes, please describe.

7. Are you currently taking any medications? If yes, please list.

8. Do you currently exercise? If yes, how many times per week & what type.

9. Do you currently use alcohol and/or recreational drugs?

10. Do you have a history of alcohol and/or substance abuse?

11. List other therapy or counseling you have received in the past or are receiving now:

Additional Information

What has helped you manage or endure your current problem or problems?

Please describe the people in your life that currently play a supportive, influential, or friendship role.

What do you enjoy doing in your free time? What are your passions? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief.

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

Is there anything else that you would like your therapist to know that has not been covered?

Signature

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my therapist of any changes in my personal circumstances including symptoms experienced, suicidal thoughts and/or substance use.

Client Signature____Date ________________

Mary Jean Padalino, LLC

Office & Confidentiality Policies

Compliance with appointments is the key to successful therapy sessions. If you fail to show for your scheduled session, or you cancel with less than 24 hours notice, you will be charged for your session in full. This fee will be payable by you and cannot be processed through your insurance company. Exceptions may be made on a case-by-case basis if a sudden illness or inclement weather arises, preventing you from coming to your appointment.

I do not accept insurance; therefore I am considered an out of network provider. Payment is due in full at the time of each session. You will receive a receipt to submit to your insurance company, should you have out of network benefits and may be able to be reimbursed. The cost is $150 for each 50 minute session. It is your sole responsibility to know your insurance benefits as I cannot guarantee that they will reimburse you, and at what rate. A $30 return check fee will be charged for any checks that are returned by your bank.

A release form must be filled out if you would like your information shared with anyone outside of Mary Jean Padalino, LLC. All sessions are considered completely confidential unless you give written permission. If you are at risk of hurting yourself or others, we are obligated by law to take reasonable precautions to ensure safety. Courts may also subpoena treatment records.

I have read and agree to all of the above statements regarding the office policies/ procedures at Mary Jean Padalino, LLC.

Client Name: ________________________________ **DOB:** ____________________

Signature: ___________________________________ **Date:** ____________________

Printed Name: _______________________________

Relationship to Client: _________________________

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Credit Card Authorization Form

I, ____ understand that my credit card listed below will be charged a non-refundable fee of $150 in the event that I do not show for a scheduled appointment, do not inform my therapist of my need to cancel/reschedule my appointment at least 24 hours before my scheduled appointment time, OR in the case of nonpayment due to a bounced check. Further, I understand that there is a $30 fee for bounced checks. The following signature authorizes Mary Jean Padalino, LLC to both keep my credit card information on file for services rendered, as well as charge my credit card, in the case of aforementioned circumstances.

____

Print Name (Cardholder)

____

Signature (Cardholder)

____

Date

Please be sure to notify Mary Jean Padalino, LLC of any change to this information.

Credit Card Number: ____

Security Code: ___________________________

Expiration Date: (MM/YY) ________________

Billing Zip Code:__________________________

Name as it appears on the card:____

Limits of Confidentiality

*Psychotherapy is confidential, with the below stated exceptions.:

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety. This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: In keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature:_______________________________________Date:____________