THE BINDU INSTITUTE
COUNSELING • COACHING • CONSULTING

Couple's Counseling Initial Registration/Intake Form

Client Name: *Last* _____ , *First* _____ ***Today's Date:*** *(mm/dd/yyyy)* _____
Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____
Daytime Phone: (___)_____-_____ ***Alternate Phone:*** (___)_____-____ ***Gender:*** *Male* ☐ *Female* ☐
Sexual Orientation: *Heterosexual* ☐ *Homosexual* ☐ *Bisexual* ☐ *Other* ☐

_____
Email: _____ **Date of Birth:** ____/____/_____
Referred by: _____ *OK to thank referrer?* ☐

Chief Concern; *Please describe the main difficulty or issue that has brought you to here:* _____
_____
_____
_____

Treatment History; *Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?* No ☐ Yes ☐ *If yes, please indicate:*

When?	From whom?	For what?	With what result?

Have you ever taken medications for psychiatric or emotional problems? No ☐ Yes ☐ *If yes, please indicate:*

When?	From whom?	Which medication?	For what?	With what result?

Relationships in your family of origin; *Please describe the following:*

1. *Your parents' relationship with each other:* _____
   _____
   _____
2. *Your relationship with each parent and with any other adults present:* _____
   _____
   _____
   _____

Relationships in your family of origin (continued); *Please describe the following:*

3. *Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:*
   _____
   _____
   _____
   _____
4. *Your relationship with your brothers and sisters, in the past and present:* _____
   _____
   _____
   _____
   _____

Abuse History: ☐I was not abused in any way. ☐I was abused. *If you were abused, please indicate the following. For type of abuse, use these letters:* P = Physical, such as beatings, S = Sexual, such as touching/molesting, fondling or intercourse, N = Neglect, such as failure to feed, shelter, or protect, E = Emotional, such as humiliation, etc. *If more than one kind of abuse applies, use multiple letters.*

Your age at the time	***Type of abuse***	***By whom?***

Present relationship:

5. *How long have you been in your current relationship?* _____
   _____
   _____
6. *How do you get along with your present spouse or partner?* _____
   _____
   _____
   _____
   _____
7. *List your partner's strengths:* _____
   _____
   _____
8. *What are the greatest challenges to your relationship?* _____
   _____
   _____
9. *What would be the ideal outcome of counseling with respect to your relationship?* _____
   _____
   _____
10. *List briefly things you are willing to change to improve the relationship:* _____
    _____
    _____

11. Your important friends, past and present:

Names	***Good aspects of the relationship***	***Bad aspects of the relationship***

12. List below any children you or your partner have, their ages, and if currently reside in the home or elsewhere.

1. _____
2. _____
3. _____
4. _____
5. _____

Chemical Use:

1. *How many cups of regular (caffeinated) coffee do your drink each day? _____ How many cups of (caffeinated) tea? _____ How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? _____ How many "energy drinks?" _____ How often do you use NoDoz or similar pills? _____*
2. *How much tobacco do you smoke or chew each week? _____*
3. *Have you ever felt the need to cut down on your drinking (alcohol)?* No ☐ Yes ☐
4. *Have you ever felt annoyed by criticism of your drinking (alcohol)?* No ☐ Yes ☐
5. *Have you ever felt guilty about your drinking (alcohol)?* No ☐ Yes ☐
6. *Have you ever taken a morning "eye-opener?"* No ☐ Yes ☐
7. *How much beer, wine or hard liquor do you consume each week on the average? _____*
8. *Are there times when you drink to unconsciousness, or run out of money as a result of drinking?*
   _____
   _____
   _____
9. *Have you ever used inhalants ("huffing") such as glue, gasoline, or paint thinner?* No ☐ Yes ☐
   If yes, which and when? _____
10. *Which drugs (not medications prescribed for you) have you used in the last 10 years? _____*
    _____
    _____
    _____
    Please provide details about your use of these drugs or other chemical, such as amounts, how often you used them, their effects, and so forth: _____
    _____
    _____
    _____

Legal History:

1. *Are you presently suing anyone or thinking of suing anyone?* No ☐ Yes ☐ *If yes, please explain:*
   _____
   _____
   _____
   _____

2. *Is your reason for coming to see me related to an accident or injury?* No ☐ Yes ☐ *If yes, please explain:* _____
_____
_____
_____
_____

3. *Are your required by a court, the police, or a probation/parole officer to have this appointment?* No ☐ Yes ☐ *If yes, please explain:* _____
_____
_____
_____
_____

Legal History (continued):

4. *List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction" wrote in a letter: F = Federal, S = State, Co = County, Ci = City. Under "sentence" write in the time and the type of sentence you served or are facing: (AR = accelerated or alternative resolution, CS – community service, F = fine, I – incarceration, Pr = probation, Po = parole, O = other, R = restitution).*

Date	***Charge***	***Jurisdiction***	***Sentence***	***Probation/Parole Officer's Name***	***Your attorney's name***

5. *Who is your current attorney? (optional, must sign release for us to communicate with attorney): Name:* _____ *Phone:* _____

6. *Are there any other legal involvements?* _____
_____
_____

Other: *Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper.* _____
_____
_____

Signature: *In signing below, I attest that I have answered all questions honestly, fully and accurately to the best of my ability*

Client: _____ ***Date:*** ____/____/_____
mm/dd/yyyy

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Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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www.TheBinduInstitute.com

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name:
Age:
Sex: ❑ Male ❑ Female Date:

If the measure is being completed by an informant, what is your relationship with the individual?

In a typical week, approximately how much time do you spend with the individual? hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by "feeling nervous, anxious, frightened, worried, or on edge", "feeling panic or being frightened", and/or "avoiding situations that make you anxious" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	

Total/Partial Raw Score:	
Prorated Total Raw Score:	
T-Score:	

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LEVEL 2—Depression—Adult

PROMIS Emotional Distress—Depression—Short Form

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date: _____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Anger—Adult*

*PROMIS Emotional Distress—Anger—Short Form

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "feeling irritated, grouchy, or angry" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I was irritated more than people knew.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt angry.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt like I was ready to explode.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I was grouchy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt annoyed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

The Bindu Institute Notice of Privacy Practices (Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting

area, and you can always get a copy of it from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Alice Malcolm, and can be reached by phone at or by e-mail at alice@TheBinduInstitute.com

The effective date of this notice is May 31, 2019.

THE BINDU INSTITUTE
COUNSELING • COACHING • CONSULTING
1913 Highway 87
Navarre, FL 32566
(850) 692-9824

The Bindu Institute Consent to Use and Disclose Your Health Information

This form is an agreement between you, and The Bindu Institute, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

.

_____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.thebinduinstitute.com, or by calling us at (850) 692-9824. Please ask to speak to our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative | Date

_____ _____

Printed name of client or personal representative | Relationship to the client

_____ _____

Description of personal representative's authority | Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

THE BINDU INSTITUTE
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Financial Information and Policy - Mental Health Counseling Services

We truly appreciate your choosing The Bindu Institute. As part of providing high-quality services, we need have accurate insurance information and be clear about our financial arrangements.

A. Client Information

Client's name: _____ Date of Birth: _____Soc. Sec. #: _____

Home Address: _____Contact phone: _____

(If the client is a minor we will need the name, birth date, and Soc. Sec. # of parent/guardian:

Full name of parent/guardian: _____ Date of Birth: _____ Soc. Sec. #: _____

B. Insurance Information

If you have insurance you would like us to use/file, please fill in the information in this Section.

Full name of policy holder/subscriber (if not the patient):_____

Insurance Company: _____ Policy Number: _____

If you have other (secondary) insurance, complete below:
Full name of policy holder/subscriber (if not the patient):_____
Insurance Company: _____ Policy Number: _____

C. Payment Method

If you do not have insurance, how will you pay for services from this office?
❑ Cash ❑ Check ❑ Debit/Credit Type of Card: ☐ Visa ☐ M/C ☐ Discover ☐ Other: _____
Card Number (16 digit): _____ Exp. Date: _____ Security Code: _____

D. Returned Checks

There will be a $25.00 charge for returned checks.

E. Release of Information to Insurance Company

I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

F. Billing

I understand that I am responsible for all charges, regardless of insurance coverage. Payment for all client statements is due in full upon receipt. Payment arrangements can be made in advance for some accounts. A divorce decree cannot assign responsibility for an adult's or child's account. Failure to pay your bill will result in your account being turned over to a collection agency. Only your account status will be discussed with the collection agency.

G. Appointment Cancellation Policy

Our staff at The Bindu Institute is committed to our clients and we continue to accept new clients. A missed appointment means that other clients were not able to make use of the appointment time missed. Therefore, we require a credit card number in order to hold your appointment time. If for any reason you are unable to keep you're appointment, please call at least one business day in advance to allow us to schedule that time for another client. If you fail to notify us prior to one business day before your schedule appointment, a $60.00 will be applied. If more than two sessions are missed without proper notification, continued services will be re-evaluated. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to The Bindu Institute. A photocopy of this assignment is to be considered as good as the original.

My signature below acknowledges that I have read, fully understand, and agree to all parts of the financial policy of The Bindu Institute.

_____ _____
Client's (or parent/guardian's) signature, indicating agreement to the Financial Policy Date

_____
Printed name