Kate Giandonato & Associates
1100 W. Lake Street Suite 201 Oak Park, IL 60301
Phone: (773) 766-7010 • Fax: 708-970-8097• e mail: katelcsw@gmail.com •
www.katelcsw.info

Today's Date: ____________

<table>
<tr><td colspan="3">Client Information:</td></tr>
<tr><td>Full Legal Name:</td><td colspan="2">Preferred Name (If Different):</td></tr>
<tr><td>How do you identify:
Girl Boy Woman Man
Transmasculine Transfeminine
Genderqueer
Or, describe your gender:</td><td colspan="2">My pronouns are:
She/her He/him They/them
Or:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2">Current Age:</td></tr>
<tr><td>Your gender recorded by your insurance carrier: Insurance companies continue to require that gender is identified as male or female for billing purposes.
Female Male</td><td colspan="2">What sex were you assigned at birth?
Female Male Decline to answer</td></tr>
<tr><td rowspan="2">Home Address (Please include zip code):</td><td>Home/Cell Phone:</td><td>Email Address:</td></tr>
<tr><td>May we leave a message?
May we text you?
May we email you?
May we send you appointment reminders via email?</td><td>Yes No
Yes No
Yes No
Yes No</td></tr>
<tr><td>Primary Language:</td><td colspan="2">Referred By:</td></tr>
<tr><td>Emergency Contact: (please note that we will only contact this individual without expressed consent from you if we are immediately concerned for your physical safety)</td><td colspan="2">Phone Number:</td></tr>
</table>

Parent/Legal Guardian Information: N/A	
Name:	**Name:**
Home Address: Same as client	**Home Address: Same as client**
Home/Cell Phone **Same as client**	**Home/Cell Phone** **Same as client**
Email: **Same as client**	**Email:** **Same as client**
Date of Birth:	**Date of Birth:**
Caretaker's Job:	**Caretaker's Job:**

Insurance Information: N/A	
Insurance Company Name:	**Subscribers Name:** **(Include DOB if different than above)**
ID#:	**Group #:**
Insurance Phone # (Typically on the back of the card):	**Additional Information (effective date, authorization etc):**
Your insurance provider might have a deductible that must be met, depending on your particular insurance policy. Please contact your insurance company for more detailed information regarding their policies and procedures. Also, please refer to our service agreement and consent for treatment for further information.	

Household Information:

Client primarily lives with: **Mother** **Father** **Both** **Other_______**			
Sibling Names:	**Date of Birth:**	**Occupation/Grade in School**	**Medical/Mental Health Concerns:**

Presenting Concerns: *(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)*	
Please share what brought you/your family to seek treatment at this time:	
Are you receiving psychiatric services or therapeutic services elsewhere? May I contact them? **Yes** **No** *(please complete the release of information form included in this packet)*	**Please list the name of practice/provide**r:
Are you currently taking any prescribed psychiatric medication? Yes No	**Please list psychotropic medications:**

Prior Mental Health Experience:		
Have you previously had therapy? **Yes** **No**	**Where did you receive services?**	**How was your prior therapy experience?** *(i.e what worked for you, what didn't)*

Health and Social: *(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)*

How would you rate your current physical health?

|---|

Poor **Good** **Excellent**

List any chronic or persistent physical symptoms or health concerns *(include date of diagnosis):*	**List your primary care physician and any other medical professionals who treat you** *(pediatrician, OB/GYN, chiropractor, etc) :* **May we contact them? Yes No** *(if yes, please fill out the Release of Information form included in this packet).*

Symptom Checklist:

(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)

Are you currently experiencing….

□ Have you had any suicidal thoughts recently? □ Have you had any suicidal thoughts in the past? □ Difficulty Sleeping (Falling Asleep/Staying Asleep) □ Appetite/Eating issues □ Extreme depressed mood □ Extreme mood swings □ Rapid speech □ Extreme anxiety □ Panic attacks □ Phobias □ Sleep disturbances □ Hallucinations □ Unexplained memory loss □ Forgetful/memory problems, □ short attention span □ aggressive behavior □ can't sit still □ bedwetting/soiling □ talks frequently □ interrupts others □ self harm □ easily annoyed □ annoys others □ Alcohol/substance use □ Eating disorder □ Body image problems □ Homicidal thoughts □ suicidal thoughts □ Repetitive behaviors (frequent hand washing, checking) □ Repetitive thoughts (constant ruminations, obsessions)

If yes, Please describe *(also list any additional symptoms you want us to be aware of) :*

Family Mental Health History:

Has anyone in your family experienced difficulties with the following?
(Please check the box and list their relationship to you/the patient)

□ Depression_________________________ □ Bipolar Disorder (I/II) ________________ □ Schizophrenia _______________________ □ Alcohol/Substance Abuse______________ □ Suicide Attempt ______________________	□ Panic Attacks_________________________ □ Eating Disorders ______________________ □ Trauma History_______________________ □ Anxiety Disorders_____________________ □ Completed Suicide ____________________

Please add more information if you would like:

Occupational/Academic Information:

(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)

□ **Occupational:**	□ **Academic:**
Are you currently Employed? Yes No	**Are you currently in school? Yes No**
Name of current employer:	**Name of current school:**
What is your current position?	**Current grade level/Teachers name:**
Are you satisfied with this position? *(please list why or why not)* **Yes No**	**Special Education? Yes No** (*if yes, please note primary designation):* **LD/BD/Other** **Name of school Social Worker:**

List any work related stressors or concerns you want us to know:	**List any academic related stressors or concerns you want us to know:**

Religious/Spiritual Information: *(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)*	
Do you consider yourself to be religious: Yes No	**If yes, what faith do you practice?**
Do you consider yourself to be spiritual?	**What would you like us to know about your spiritual experience?**

Personal: *(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)*	
What are your strengths?	**What do you like most about yourself?**
What would your perfect/ideal day look like?	**How do you like to spend your free time? (hobbies/interests etc):**
If you could have any superpower, what would it be and why?	

Acknowledgement our Policies and Service Consent:

(if the client is 12 or older, please ensure that this section is completed primarily by the client with parental support as warranted)

Please ask before signing below if you have any questions about treatment or office policies. Your signature indicates that you agree to enter treatment under these conditions. Your signature below notes that you are making an informed choice to consent to treatment and understand and accept the terms of this agreement. The undersigned agrees that "Services Contract", "Notice of Privacy Practices" and "E-mail, Phone and Social Media Use Disclosures" have been read in full and are understood. They detail information related to treatment and payment, as well as the Health Insurance Portability and Accountability Act (HIPAA) and your rights for privacy protection.

The undersigned understands that they have the right to:

1. Be informed of and participate in the selection of treatment modalities;
2. Receive a copy of these consents
3. Withdraw these consents at any time.

I have read and agree to the terms in the Services Contract:

Patient Name(printed):	Patient Name(printed):
Patient Signature:	Patient Signature:
Date:	Date:

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Credit Card Authorization Form:
Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ▫ Other	
Cardholder Name (as shown on card):	**Card Number:**
Expiration Date (mm/yy):	**CID (Security Code 3-4 digits):**
Cardholder ZIP Code *(from credit card billing address):* ___	
I,________________________________, authorize Kate Giandonato & Associates to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.	

Customer Signature:	Date:

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Release of Information (Reciprocal)		
Client Name:	**Date of Birth:**	**Client Address:**
I hereby authorize the release of the following specific information: *Please check to indicate consent for release of this information to the below provider*		
□ Medical history, examination, laboratory tests and treatment reports □ Periodic reports of current treatment progress, including attendance and participation	□ Psychological test reports □ Social history data including family, education, employment & other relevant material □ Other (please specify)	□ Psychiatric evaluation reports □ Summary of previous mental health and/or counseling services □ Notification of referral source of initiation and termination of counseling
I hereby authorize the release of this information to be reciprocal between both Kate Giandonato & Associates and:	**Name of Agency or Individual**	**Agency or Individual's contact information**: *(Please include physical address, phone number and email address)*
□ to develop and assess counseling and casework plan □ to coordinate medical, psychological and social rehabilitative process. □ other (please specify):		
I understand that no information may be re-disclosed by either agency to any other individual or agency unless by my written consent. This authorization may be revoked at any time by my written statement and it is automatically revoked at the end of one year from date authorization was signed or under the following specific conditions:		

This release expires on:		
Signature of Client:	**Date:**	
Signature of Responsible Party for Minor:	**Relationship to Minor:**	**Date:**
Signature of Therapist:	**Date:**	