Alexis Lake, MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

Brief Health Information Form

1. Identification:

Clients name: ______________________________ Date: ____________________

2. History:

A. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (describe pregnancies in section E)

Age	Illness/diagnosis	Treatment received	Treated by	Result

B. Describe any allergies you have

To what	Reaction you have	Allergy medications you take

C. List all medications, drugs, or other substances you take or have taken in the last year – prescribed, over the counter, vitamins, herbs, and others.

Medication/drug	Dose	Taken for	Prescribed & supervised by

D. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

3. Medical caregivers

A. List your current family or personal physician or medical agency:

Name	Address	Phone number	Last visit

B. Other physicians treating you at present or in the last 5 years:

Name	Specialty	Address	Phone number	Last visit

4. Health habits

A. What kinds of physical exercise do you get? ____________________

____

B. How much coffee, tea, cola, or other sources of caffeine do you consume each day? Which? ____________________

____

C. Do you try to restrict your eating in any way?

How? ____________________

Why? ____________________

D. Do you have any problems getting enough sleep? __________ If yes, what problems? __________

____

5. For women only

A. At what age did you start to menstruate (get your period)? ____________________

B. Menstrual period experiences:

1. How regular are they? ____________ How long do they last? ____________

2. How much pain do you have? ____________ How heavy are they? ____________

3. Other experiences during periods: ____________________

C. Please list all your pregnancies:

Your age	Problems	Miscarriage	Abortion	Child born

D. Menopause:

1. If your menopause has started, at what age did it start? ____________________

2. What signs or symptoms have you had? ____________________

____

6. Other:

A. Do you use tobacco? ____ If yes, how many cigarettes/cigars/other do you use each day? ____________

B. Have you ever injected drugs? ________ Ever shared needles? ____________________

C. Are there any other medical or physical problems you are concerned about? ____________________

____

7. Family Health History:

Person	Age/age at death	Health Problems	Cause of Death
Father			
Mother			
Paternal G/F			
Paternal G/M			
Maternal G/F			
Maternal G/M			
Siblings/others			

Alexis Lake, MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

Mental Health Information Form – please give some detail

1. Is stress a problem for you?

2. Do you panic when stressed? How often?

3. Are you depressed?

4. Do you cry frequently?

5. Do you have trouble sleeping?

6. Do you no longer enjoy the things you once enjoyed?

7. Do you often wonder why "we are here" or feel hopeless?

8. Have you ever thought of hurting yourself or killing yourself?

9. If you have thought of hurting or killing yourself, did you have a plan?

10. Have you ever been diagnosed with a mental illness? When? What?

Alexis Lake MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. The full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

Client signature (parent/guardian if under 18) Date

Alexis Lake MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

Consent to treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedure provided by this therapist.

I am freely choosing to enter treatment and I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to face other problems if I stop treatment. (for example, if my treatment has been court ordered, I will have to answer to the court)

I know that I must call to cancel an appointment at least 24 hours before the appointment. If I do not cancel and I do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any service or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

____

Printed name, relationship to client if needed   Date:

____

Signature of client (or person acting for client)   Date:

I, Alexis Lake, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Signature of therapist   Date:

☐ Copy accepted by client   ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly forbidden by law.

Alexis Lake MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult), or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Supervision

Understand that your therapist will from time to time review your case with a more experienced "supervisor". The purpose of this supervision is to ensure the best care possible is being provided. You have a right to know who these supervisors are.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____

Client signature (parent/guardian if under 18) Date

Alexis Lake MSS, LCSW
Licensed Clinical Social Worker, Therapist
PA CW019825
(717) 575-3757
alaketherapy@gmail.com
www.alaketherapy.com

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.

I am required by law to keep your information private. These laws are complicated, but we must give you this important information. The full, legally required notice of privacy practices is available upon request.

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

Disclosing heath information without your consent

There are some times when the laws require me 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. I will only share information with persons who are able to prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers compensation and similar benefit programs.

There are 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 me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to look at the health information I have about you, such as your therapy and billing records. You can get a copy of these records, but we may charge you for it.

3. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You must make this request in writing. You must also tell me the reasons you want to make the changes.

4. You have the right to a copy of this notice. If I change this notice, I will post the new version in my waiting area, and you can always get a copy from me.

5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me 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 I provide to you in any way.

Name: ______________________________ Date: ______________

Signature: ______________________________