Client Intake Form

Solutions Program for Eating Disorders
Dr. Virginia Porcello, PhD, LMHC, CEDS
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Email: drporcello@solutionsprogram.net
Web: www.solutionsprogram.net

DEMOGRAPHIC INFORMATION

Name _____D.O.B. _____

Male ☐ Female ☐

Legal Guardian if client is a minor _____

Relationship _____

Address _____City_____

State _____Zip _____ Phone (H)_____(M)_____

Email _____

Emergency Contact Name _____

Emergency Phone Number _____

Occupation _____

Employer _____

Length of Employment _____

Marital Status:

❒ Single ❒ Married

❒ Separated ❒ Divorced

❒ Widowed ❒ Other

Spouse's Name _____

Spouse's Age _____

Occupation _____ Years Married _____

Children:

Name	Age	Gender	Weight issues? (Y or N)	Where does the child live?

INSURANCE INFORMATION

Name of Insured _____

Insured's Workplace _____

Primary Insurance Company_____Phone_____Co-Pay Amt. _____

ID#_____ Group ID# _____

Secondary Insurance Company_____Phone_____Co-Pay Amt. _____

ID#_____ Group ID# _____

MEDICAL HEALTH INFORMATION

Primary Care Physician_____Phone_____

Psychiatrist_____Phone_____

Date of last medical examination _____

Report

_____

_____

_____

_____

List any medical conditions you have now or in the past:

Medical Condition	Date Diagnosed

Rate your health (check): Very Good_____ Good _____ Average _____Declining _____

Current Weight_____ Current BMI_____

Weight Changes recently: Lost _____Date_____ Gained _____Date_____

Are you presently taking medication? Yes ____ No ____

Please list current medications/dosage:

Current Medication	Dosage	Reason Prescribed

Please list any surgeries you've had in the past:

Surgery Type	Surgery Date

Current Issue(s) bringing you to counseling:

_____

_____

_____

_____

Have you ever been in psychotherapy? _____

Length of time in treatment_____

Are you currently in psychotherapy? _____

If yes, with whom?_____Time period_____

What type? Individual_____Group_____Family_____Marital Counseling_____

For what reason? _____

_____

_____

Are you currently involved with any exercise routine? If so, please explain _____

_____

_____

_____

Family History

Mother : Living_____Age_____ eating problems? _____medical problems_____ _____

Deceased_____ Date_____ Cause_____

Father: Living_____ Age_____ eating problems?_____ medical problems_____

Deceased_____Date_____ Cause_____

Siblings: List all siblings, oldest first:

Living_____ age_____ weight/eating problems?_____

City and State where they live: _____

Married/Single_____ Children_____

Relationship with Sibling Positive _____ Neutral _____ Negative _____

Explain:

_____

_____

_____

_____

_____

Living_____ age_____ weight/eating problems?_____

City and State where they live: _____Married/Single_____

Children_____

Relationship with Sibling Positive _____ Neutral _____ Negative _____

Explain:

_____

_____

_____

_____

_____

Living_____ age_____ weight/eating problems?_____

City and State where they live: _____Married/Single_____

Children_____

Relationship with Sibling Positive _____ Neutral _____ Negative _____

Explain:

_____

_____

_____

_____

_____

Any history of obesity on (maternal) mother's side of the family? YES___ NO___
If yes, please list names and relationship to you:

_____

_____

_____

_____

Any history of obesity on (paternal)Fathers side of the family? YES ___ NO ___
If yes, please list names and relationship to you:

_____

_____

_____

_____

Any history of bulimia or anorexia in family history? YES ____ NO ____
If yes, please explain:

Any history of alcohol or drug use in family history? YES ____ NO ____
If yes, please explain:

Are you a smoker? YES _____ NO _____

Any history of sexual abuse for you or a family member? YES ____ NO ____
If Yes, explain:

FAMILY HISTORY OF MENTAL ILLNESS: Please list any members who have been in counseling and the reasons why or who have been hospitalized for mental illness:

Weight History

What is your first memory of being overweight? How old were you? Please write as much information as you can:

_____

_____

_____

_____

_____

_____

_____

_____

Your most stable adult weight you have maintained: _____ pounds ,lasting _____ ❒ months
❒ years at age(s) _____

My current weight is _____ pounds. My most accurate height is ____ feet, ____ inches

Emotional Eating History and Behaviors

EMOTIONAL EATING HISTORY

How often do you obsess about your body?_____

How often do you obsess about eating?_____

How often do you disapprove of the way you look?_____

What percentage of your compulsive eating is emotional or do to stress (0 to 100%)_____

EATING BEHAVIORS

On the average WORKDAY, I eat ____ meals and ____ snacks

On days when I am not at work, I eat ____ meals and ____ snacks

I CONSIDER MY AVERAGE MEAL SIZE TO BE::

❒ Small

❒ Medium

❒ Large

MY DIET CONSISTS MOSTLY OF (CHECK ALL THAT APPLY):

❒ "Normal Food"…….. I eat a variety of food groups similar to the food eaten by my family, friends and Co-workers

❒ "Healthy Food"……..I make an effort to buy, prepare, and eat food that is low in sugar, fat, calories

❒ "Fast food"……Much of my food is eaten "on the run" or purchased at "drive-thru window."

Type of restaurants:_____

❒ "Junk food"……..I snack a lot, mostly at: ❒ home ❒ work

MY SNACKFOOD CONSISTS MOSTLY OF:

❒ Sugar and Sweets ❒ Chocolate ❒ Salty food ❒ Sandwiches ❒ Leftovers

❒ whatever is available ❒ Other: _____

SITUATIONS:

❒ I mostly eat only when I am hungry: _____

❒ I think I eat more if I am in a stressful situation, which usually comes from (Please Describe):

Work: _____

Home: _____

Family: _____

Other: _____

❒ I tend to eat when I am bored, because_____

_____

_____

❒ I binge eat by eating a lot of food within a few hours: _____

❒ I keep food hidden at home or work so I have access to food to eat throughout the day:

_____

_____

❒ I try to eat when I know no one else can see me eating: _____

_____

I HAVE PARTICIPATED IN THE FOLLOWING WEIGHT LOSS PROGRAMS:

PROGRAM_____
How long did you stay on the program?_____
How much did you lose?_____
How long did you keep the weight off?_____
What made you start this program?_____
What made you stop this program?_____

PROGRAM_____
How long did you stay on the program?_____
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PROGRAM_____
How long did you stay on the program?_____
How much did you lose?_____
How long did you keep the weight off?_____
What made you start this program?_____
What made you stop this program?_____

If needed, please use the rest of this page to list other programs

Your routine daily diet-- list breakfast, lunch, and dinner including time of day and snacks:

Meal	**Usual Meal Time**
Breakfast	
Snack?	
Lunch	
Snack?	
Dinner	
Snack after dinner?	

If you are on a pre-bariatric weight loss program, what was your diet like before you started the program:

What are your major stressors in your life today and how do you handle them:

Have you ever had feelings/thoughts of hurting yourself or others?

If yes, please explain:

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AUTHORIZATION FOR RELEASE OF INFORMATION:

I am currently in treatment with Virginia Porcello, Ph.D. for psychotherapy.
I give Dr. Porcello permission to speak with my medical doctors regarding my medical treatment.

Date **Patient Signature**

Informed Consent Form

Please read the following information and sign at the end to indicate that you understand the policies and procedures of Dr. Porcello and Solutions Program for Eating Disorders.

- **Services:** Virginia E. Porcello, Ph.D., LPC, LMHC provides many different types of therapy for individuals, teenagers, families, and couples, in addition to eating disorders, bariatric evaluations, and Telemedicine mental health. The length of treatment may vary depending on the therapist and client's collaborative efforts (s). The therapy goals are developed with the therapist, are based on the client's needs and concerns, and are reviewed periodically to monitor progress. We consider treatment/therapy an active process and therefore prefer clients to play an active role in their therapy. Additionally, counseling services are voluntary. If the client has been court-ordered for treatment, a copy of this documentation must be provided before the next counseling session.
- **Telemedicine and mental health:** Telemedicine, related to mental health, involves using electronic communications (telephone, written, and/or video conferencing) to enable therapists to provide services to individuals who would otherwise not have adequate access to care. Telemedicine therapy sessions may be used for services such as individual, follow-ups, and training/education. Telemedicine mental health is a relatively recent way of delivering care, and there are some limitations compared with seeing a therapist in person. We will be using DOXY.ME as our web service. Restrictions include not having person-to-person contact and not being a good fit for all populations. The limitations can be addressed, and they are reasonably minor depending on how well the sound and video are working during the televideo/telephone session. I understand that cell phones (calls, voicemails, and text) and standard email are not as secure as a landline.
    - **a.** With the use of text-based modalities (texting and email) or video-conferencing, you should be aware that misunderstandings are possible since non-verbal cues are relatively lacking or delayed due to limited bandwidth.
    - **b.** Information transmitted may not be sufficient (i.e., poor resolution of images, technical interruptions, or unauthorized access) to allow for appropriate treatment.
    - **c.** Delays in treatment could occur due to deficiencies or failures of the equipment.
    - **d.** Telemedicine therapy sessions via a secure communication system are almost impossible for anyone else to access. Since it is still a possibility, you understand the low risk that this could affect confidentiality. In scarce instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a violation of privacy.
    - **e.** Telemedicine mental health sessions will never be recorded or photographed without your written permission.
    - **f.** If there is an emergency during a Telemedicine session, we will call emergency services and your emergency contact.
    - **g.** If the video conferencing or phone connection drops during a session, you will have a phone available to contact the therapist.

- **Appointments:** We will usually schedule one 45-60 minute session per week at a time we agree on, although some sessions may be longer or more frequent. Regular attendance to therapy is vitally important to ensure progress with the concerns and issues that have been presented. Please make every effort to keep appointments and be on time. **If you need to cancel an appointment, please call 516-625-9181at least 24 hours before the time of your appointment.** If you do not cancel more than 24 hours ahead or fail to show for an appointment, you will be charged a $50 missed appointment fee since insurance will not reimburse missed appointments. If a credit card is on file, please note, your credit card will be charged immediately for a missed appointment, or an appointment canceled less than 24 hours.
- **Therapist Information:** Your therapist, Virginia E. Porcello, holds a Ph.D. in Counseling Psychology and is currently licensed/certified in Georgia as a Licensed Professional Counselor (LPC), a Certified Professional Counselor Supervisor (CPCS), and Certified as a Tele mental Counselor. You must note that we often consult with licensed colleagues. We may discuss various aspects of your case during these consultation appointments without any identifying information to this licensed clinician for your therapeutic benefit.
- **Contacting Me:** Due to our work schedule, we are often not immediately available by telephone, email, or text. We probably will not answer the phone, email, or text when we are with a client, but when we are unavailable, we frequently monitor our voicemail, text, and emails. We will make every effort to return your message on the same business day, except for after regular business hours, weekends and holidays, but definitely within 24 hours. If you are challenging to reach, please inform us of some days and times when you will be available. Also, keep in mind, when we return your call, answer your emails, or reply to your text messages, your confidentiality may be diminished if we have to identify ourselves. If we are unavailable for an extended period of time, we will provide you with the name of a colleague to contact, if necessary. **If you have a life-threatening mental health emergency, please call 911!**
- **Fees:** Our appointment fees are as follows unless otherwise agreed upon by a Service Fee Agreement (i.e., insurance): $150 for initial intake; $180 for couples or families; $125 for individuals; $100 for Telemedicine mental health; and $200 for bariatric evaluations. Additionally, we charge $100 for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. These services are not reimbursed by insurance. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. [Because of the difficulty of legal involvement, we charge $150 per hour for preparation and attendance at any legal proceeding.]
- **Payment: Sessions are to be paid in full before the beginning of each session.** We accept cash, check, or credit cards. A $35.00 service charge is billed, based on the original amount of the check on all returned checks to be paid before your next appointment.

- **Delinquent Payments:** You will be expected to pay for each session at the end of the current session unless we agree otherwise. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court, requiring me to disclose otherwise confidential information. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its cost will be included in the claim.]
- **Confidentiality:** As a client, you understand that every effort is made to keep counseling records confidential and protect your personal health information. However, there are no 100% guarantees. Safeguards are put into place to limits this risk, i.e., password protection and encryptions are used when available. The law protects the privacy of all communications between a client and a counselor. In most situations, we can only release information about your treatment to others if you sign a written authorization that meets specific legal requirements imposed by HIPAA. However, there are clear and limited exceptions to this confidentiality which include the following:

  1) If you present a danger to yourself or others, I am legally and ethically required by law to protect the safety of you and/ or the threatened person(s). This may include contacting your emergency contact person, local resources, or law enforcement.

  2) If abuse (sexual or physical) or neglect of a child, elderly individual, or disabled person is revealed, known, or suspected, I am required by law to report it to the Department of Family and Children Services.

  3) If I receive a court order/subpoena for client records, staff deposition, or court testimony, I must comply. I am also required to report attendance compliance to the court for court-ordered clients.
- **Professional Records:** The laws and standards of our profession require that we keep Protected Health Information about you in your clinical record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider), and we believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which we will discuss with you upon request.
- **Minors and Parents:** Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child or we agree otherwise. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is [sometimes] our policy to request an agreement from parents that they consent to give up their access to their child's records.

If they agree, during treatment, we will provide them only with general information about the child's treatment progress and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

- **Termination:** Your decision to enter therapy is voluntary, and you may terminate it at any time. The client is expected to inform the therapist of the client's plans to discontinue treatment for any reason. The final therapy session is an integral part of the therapeutic process, and it helps to summarize the progress and appreciate the change and growth that has occurred. If a client does not show up for two of their therapy appointments with no contact with the therapist, the case will be closed on the third week after the last attended session. If you decide to terminate therapy, you will still be responsible for any unpaid therapy sessions already received. The therapist may discontinue treatment with the client if the client is currently involved with domestic violence with a partner, has continued life-threatening substance abuse, or has shown violent or threatening behavior. In any of these events, the client will be referred to other more appropriate and intensive services for issues with substance abuse, violence, or severe mental health concern. If in our professional opinion, it is in your best interest to refer you to another therapist, we will do so because ethical standards dictate this course of action. We will provide you with the names and numbers of therapists for you to contact if you wish. Whether you choose to continue therapy with another therapist is entirely your decision.
- **Benefits and Risks of Therapy:** The majority of individuals, couples, and families in therapy benefit from the process of counseling. However, no promises can be made regarding the results of treatment or any procedures provided by the therapist. Open, honest, and accurate reporting of dilemmas and concerns are vital to progress in therapy. Self-exploration, insight, exploring options for dealing with problematic behaviors, learning new skills, or venting complicated feelings/experiences are generally beneficial; nevertheless, some risk exists. Please understand that some individuals experience unwanted feelings throughout treatment and that examining old issues may produce unhappiness, anger, guilt, or frustration. These feelings are complex, but a natural part of the psychotherapeutic process and often provide the basis for change. But there are no guarantees of what you will experience. Important decisions are usually an outcome of counseling. These decisions, including changing behavior, exploring employment opportunities, substance abuse patterns, schooling, and relationships, are likely to produce new opportunities as well as unique challenges for each individual involved. Sometimes a decision that seems positive for one person will be viewed quite negatively by another. Do not be hesitant to discuss counseling goals, procedures, or your impressions of the services being provided with your therapist. If you ever do not understand a suggestion or comment that has been made, please ask for clarification. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

My signature constitutes my agreement with the statements above, and I confirm that I have received a copy of this two-page form for my records.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

_____ _____

Virginia E. Porcello, Ph.D., LPC, LMHC Date