

**Stafford Family Counseling  
11 Hope Road, Suite 213  
Stafford, VA 22554  
540-658-0888 \* Fax 540-658-0855**

**INTAKE BIOGRAPHICAL DATA PACKET**

**PART ONE TO BE COMPLETED BY PATIENT OR GUARDIAN**

**PATIENT DEMOGRAPHIC INFORMATION**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (Home): \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Guardianship (for children and adults when applicable): \_\_\_\_\_

Marital Status: \_\_\_\_\_

Example- never married, married, widowed, divorced, separating, cohabiting

Gender: \_\_\_\_\_ Age: \_\_\_\_\_

**Family Members** (Living with you)

Name	Age	Sex	Relationship
_____			
_____			
_____			
_____			

**Patient Name:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_ 1

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Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

School (for children, and adults when applicable): \_\_\_\_\_

Referral Source: \_\_\_\_\_

**Emergency Information:**

Primary Care Physician or Pediatrician: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_

Phone(s): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Previous Medical History**

Allergies (adverse reactions to medications/food/etc.): \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

Findings from Exam: \_\_\_\_\_

**Current Medications** (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):

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**Hospitalizations/Surgeries** (include dates, complications, adverse reactions to anesthesia, outcomes, etc.): \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_

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**Any relevant medical conditions** (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.): \_\_\_\_\_

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**Children and Adolescents, and adults when applicable:**

Developmental History (developmental milestones met early, late, normal): \_\_\_\_\_

Child routinely followed by a pediatrician for first five years? \_\_\_\_\_

Child have any congenital defects requiring treatment e.g. heart defects, hydrocephalus, cleft lip/palate, etc.? \_\_\_\_\_

Child speech develop within normal time frames? \_\_\_\_\_

Child growth and development occur with normal time frames? \_\_\_\_\_

Child begin walking within normal time frames? \_\_\_\_\_

Child have any vision or hearing developmental difficulties? \_\_\_\_\_

Child begin school as scheduled, or was school delayed? \_\_\_\_\_

Child's early school years run a normal course, or did socialization/behavior problems exist?

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Child have any diagnosed learning disabilities? \_\_\_\_\_

Child have diagnosed hyperactivity? \_\_\_\_\_

Child have history of needing Ritalin, asthma medications, or allergy medications?

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Child exhibits tendencies to hurt other children or animals? \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_

**Pre-natal/Peri-natal History** (medical problems during pregnancy, mother's use of medications, details of labor/delivery etc.): \_\_\_\_\_

Was the pregnancy a normal pregnancy, or were there problems such as toxemia, pregnancy induced diabetes, preeclampsia, placenta previa, etc.?

Was the pregnancy full term, or was the delivery premature? \_\_\_\_\_

Did mother use drugs or alcohol during the pregnancy? \_\_\_\_\_

Is/was the mother addicted to drugs/alcohol and using during pregnancy? \_\_\_\_\_

Was the baby born addicted; requiring detox in the nursery? \_\_\_\_\_

Did the baby require time in an intensive neonatal nursery? \_\_\_\_\_

Was the birth weight considered normal, or were parents told it was too low or too high?

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Clinician's signature with professional degree indicating review of document

**Patient Name:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_  
**Stafford Family Counseling, P.C.**  
**Intake Data Packet- Patient/Guardian**

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NOTICE OF PRIVACY PRACTICES  
Effective April 14, 2003

**This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

**Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:**

**Abuse or Neglect:** If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public authorities.

**Danger:** If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to make a report to the person at risk and to the public authorities.

**Legal Proceedings:** I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

**You have the following rights regarding health information I maintain about you:**

**Right to Inspect and Copy:** You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt.

**Right to Amend:** If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by me. Your request for amendment must be in writing and must provide a reason supporting your request.

**Right to an Accounting of Disclosures:** You have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2003

**Right to Request Restriction on Uses and Disclosures:** You may request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as referral to another counselor.

**Right to Limit Reception of Confidential Information:** For example, you may request that I contact you at a certain telephone number or address. You do not have to give a reason for your request.

**Right to a paper copy of this Notice.**

**Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state and professional requirements.**

If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the US Department of Health and Human Services.

\_\_\_\_\_  
Signature of Client / Custodial Parent / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

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**Optional CREDIT CARD FORM**

Type of Card (MasterCard / Visa OR Debit card): \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name as it appears on the Card: \_\_\_\_\_

Account number on the Card : \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Amount Charged: \$ \_\_\_\_\_

Card member acknowledges receipt of goods and/or services in the amount of the total show hereon and agrees to perform the obligations set forth by the card member's agreement with the issuer. My signature as found grants permission to Prince William Family Counseling for using the provided credit card information in order to pay for services rendered.

Signature of Cardholder: \_\_\_\_\_ Date: \_\_\_\_\_

Transaction completed by (please Initial) :

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**RELEASE OF INFORMATION**

It is often necessary to consult with physicians and nurse practitioners regarding medical/ medication issues regarding our patients to insure the highest quality of care. As a result, it is helpful to have a signed release of information to your primary care physician (PCP) or nurse practitioner. In today's world it is typically the role of the PCP to be aware of all treatment you receive to help insure proper coordination of care. Your therapist needs to make your PCP aware of any referrals that need to be made for medication evaluations, to insure the PCP is aware of medication changes, to discuss the need for ruling out medical causes for observed behavioral symptoms, and to make him/her aware of your basic treatment plan (not typically the details of your case, just the general symptom presentation and treatment approach). Also, many insurance companies require that we coordinate care with a patient's PCP as part of treatment and make it a condition of continued authorization for treatment. Your signature on this form indicates that you give consent for your therapist to consult with your PCP/nurse practitioner or your child's

pediatrician,(insert name) \_\_\_\_\_ , regarding medication, substance abuse, medical, and mental health issues regarding this case.

You hereby give consent for your therapist (insert name) \_\_\_\_\_ to exchange verbal information, written information, school records, medical records, and any pertinent substance abuse history with the above named treating primary care medical provider. By signing this form you acknowledge that you understand that you may refuse to authorize release of confidential information to others if you so choose. You understand that you may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event that this consent expires automatically as described below. You are also acknowledging you understand that this information may be subject to re-disclosure by the party receiving the information and may no longer be protected. By signing this form you are allowing your primary care medical provider to accept a copy of this form as a valid consent to release information. This consent includes information, which is placed in the record after the date this consent was signed, unless noted otherwise. Your signature acknowledges that this consent expires when your case is closed OR as specified here on/when

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Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_                      Witness Signature \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

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**Informed Consent for Treatment**

I, \_\_\_\_\_ (name of patient or guardian as applicable), agree and consent to participate in behavioral health care services offered and provided at/by Stafford Family Counseling \_\_\_\_\_ (name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Patient ID:** \_\_\_\_\_  
**Stafford Family Counseling**