

**Alissa Dillon, LMHC, LCMHC
Kingston, NH 03848
(978) 857-6549**

NAME _____ Date of Birth: _____ Age ____

ADDRESS:

Street _____ City _____ State _____ Zip _____

Cell Phone: _____ Email: _____

Insurance Plan _____ Phone #: _____

Policy # _____ Group #: _____

Subscriber Information if different than above: _____ Relationship _____ DOB: _____

Name

Address & Phone #

PLEASE **CHECK** THE FOLLOWING STATEMENTS:

- Failure to attend scheduled appointments will result in **termination** of my services.
- Missing appointments will result in a fee of \$75, which **must be paid** prior to scheduling another appointment.
- I agree to pay insurance copays, deductibles and other fees as applicable.
- I authorize the release of any medical information necessary to process this claim and payment for services to Alissa Dillon.
- Your medical record is confidential will not be released to a third party without your approval

UNLESS:

- You are at a risk of committing harm to yourself or another person
- You are at risk of harm (abuse or neglect) by another person
- You are experiencing a medical event and it is considered an emergency
- You require emergency mental health screening and/or hospitalization
- A release of information for an emergency contact may be requested

Patient or Parent/Guardian: _____

Date: _____

Client Questionnaire

Client Name _____

Client # _____

In your own words, why are you seeking treatment today? (If patient is a minor, what are parent's concerns.
PLEASE TYPE INTO EACH BOX, TEXT DOES NOT CONTINUE ONTO THE NEXT LINE; IT WILL DISAPPEAR)

Mark an 'X' for each behavior or feeling you are/have recently been experiencing:

Angry Guilty Restless Fearful Sad Anxious Unhappy

Other _____

Drinking more than usual Decrease in motivation Suicidal thoughts

Engaging in risky behaviors Poor concentration Aggressive behaviors

Sleeping: increased decreased Nightmares

Difficult with: falling asleep staying asleep

Appetite: increased decreased

Employment _____

Support network (family/friends/etc.) _____

Support network (friends/family/etc) Describe relationship with significant others/partners _____

Number of children _____

Current living situation _____

Significant life events: (Marriages/divorces/deaths/losses)

**PLEASE TYPE INTO EACH BOX, TEXT DOES NOT
CONTINUE ONTO THE NEXT LINE; IT WILL DISAPPEAR)**

Current life Stressors

Have you been in therapy before?

(If yes, How long ago?):

Are you CURRENTLY in treatment with another therapist? If yes, Clinician's name:

Are you taking any medications:

What do you hope to gain from treatment?

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name

DOB

I authorize Alissa Dillon, LMHC, LCMHC to

Obtain

Disclose

Exchange

Emergency Contact

my protected health information, including psychiatric/mental health information with:

Name:

Address:

Phone/Fax:

Information that may be obtained/disclosed/exchanged include: (check all that apply)

Intake Assessment

Treatment Plan

Progress Notes

Psychiatric Evaluation

Primary Care Doctor for coordination of care

Other (please specify)

Date of treatment:

to

OR **All dates of treatment**

- I understand I may revoke this release of information at any time by informing both parties of my decision. This release will expire upon termination or completion of services.
- In cases where joint custody of a child exists, records/information may be released to each parent, at the clinician's discretion.

**

I authorize the release of information pertaining to drug/alcohol treatment. (I may refuse release of this information).

The purpose of this release is:

Client (Parent/Guardian)

Date

Witness

Date