Jill Carl, LCSW
Licensed Clinical Social Worker
2121 So. Oneida St., Suite 332
Denver, CO 80224
303-903-5728 ~ Fax 303-759-0266
jill@jillcarl.com ~ www.jillcarl.com

Confidential Client Information Form
Today's date: _____

A. Identification:
Your name: _____
Date of birth: _____ Age: ____
Preferred Name: _____
Home street address: _____ Apt.: ___
City: _____ State: _____
Zip: _____
Home/evening phone: _____
E-mail: _____
Cell phone: _____
I prefer to get calls ❑ at home ❑ at work ❑ on my cell phone
Calls or e-mail will be discreet, but please indicate any restrictions:

Relationship Status: ▫ Married ▫ Single ▫ Separated ▫ Divorced ▫ Widowed
▫ In a committed relationship
Partner: ▫ Male ▫ Female
Partner's Name: _____
If you have children, please list their names and ages:
_____

B. Referral: Who gave you my name to call?
Name: _____
Phone:_____
If a healthcare professional, may I have your permission to thank this person for the referral?
❑ Yes _____ (please initial) ❑ No

Are you using insurance or paying privately? _____

C. Insurance Information
Name of insurance company: _____
Are you using medical or EAP Benefits? _____
ID number: _____ Group Number (if any): _____
Policyholder's first and last name: _____
Policyholder's date of birth: _____

Policyholder's employer: _____
Policyholder's address (if different): _____
What is your copay? _____
Insurance company phone number: _____

D. Emergency Information:

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____ Relationship: _____

E. Your Medical Care:

From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Date of last physical/medical exam: _____
Relevant medical conditions (history, current condition, changes in condition):
Medications currently taking (dosage, how long, prescribing professional):
_____

Allergies/adverse reactions to treatment recently or in the past:
_____

If you enter treatment with me, would you like me to contact your medical doctor so that s/he can be fully informed and we can coordinate your treatment?
❑ Yes (please complete Release of Information) ❑ No

F. Family and Personal History:

Past therapy or psychiatric treatment:
_____
What, if anything, was helpful?
_____

Psychiatric Hospitalizations (Dates and Locations):
_____
Family history of mood disorders, therapy or psychiatric treatment:

Family history of suicide:

Do you drink coffee? Y or N (#__ cups daily) Cigarettes? Y or N (# ___per day)

Alcohol? Y or N (# ___ drinks weekly) Date last drank _____

Recreational Drug Use (Marijuana, Cocaine, Methamphetamine, etc)? Y or N
_____

Police/Probation involvement (past or present) Y or N Date _____
Please explain: _____

Who lives in your household? Please provide names, ages and relationship to each person. _____
_____
_____

G. Your Current Employer:
Employer: _____ Occupation: _____
Work phone: _____
Is it okay to call you at work? Y N

H. Educational History:
High School (Name and City): _____ Graduate? ❑ No ❑ Yes _____ (year)
Vocational Training (if applicable): _____
Graduate? ❑ No ❑ Yes _____ (year)
College (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)
Graduate Studies (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)

Did you ever have any significant educational concerns or support, such as reading support, speech/language? Repeat or skip a grade, or receive gifted services? If so, please describe:
_____

I. Religious and Racial/Ethnic Identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ none ❑ Atheist/Agnostic ❑ other (specify):
_____
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life?
_____
Ethnicity/national origin: _____
Race: _____
or other similar way you identify yourself and consider important:
_____

J. Chief Concern
Please describe the main difficulty that has brought you to see me:

_____
_____
_____
_____
_____

Additional Concerns:
Please circle if you have experienced any of the following (past or present):

- Worry
- Poor concentration
- Mood changes
- Fear
- Panic Attacks
- Tearfulness
- Fatigue
- Feeling hopeless/helpless
- Sleep problems
- Body image problems
- Sexual Problems
- Losses
- Phobias
- Learning Problems
- Spending Sprees
- Outbursts of Anger
- Domestic Violence
- Lying
- Seizures
- Head Injury
- Gambling Problems
- Computer Addiction
- Sexual Abuse
- Trauma
- Physical Abuse
- Suicide Attempts
- Suicidal ideation
- Auditory Hallucinations (hearing voices)
- Visual Hallucinations (seeing things others don't see)

Other concerns or issues not mentioned above:

_____

_____

_____

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I have received the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____
Client Name (Printed)

_____
Client Signature

_____
Date

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Consent to Treatment

I consent to participation in psychotherapy services with Jill Carl, LCSW and I agree to the policies of her practice as detailed in the Disclosure Statement. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have been given a copy of this document for my own records.

_____ Your initials indicate that you understand the 24-hour notice cancellation policy and the $50 late cancellation fee for 60-min sessions and $75 for 90-minute sessions. Exceptions include: family emergencies, unexpected illness, severe weather-related issues.

_____
Client Signature Date

_____
Client Printed Name

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

_____ _____
Jill Carl, LCSW Date

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Electronic Communication

If you agree to communicate via electronic communications such as text, email, telephone, or any other electronic method of communication such as FaceTime or Skype, I cannot guarantee that those communications will remain confidential due to the unsecured nature of these methods of communication. However, confidentiality, by law, does extend to those electronic communications. You have the option to set up a client portal on Jituzu and to participate in video sessions via this HIPAA-compliant platform.. Also, you agree and understand that electronic communication is, in general, for business-related or logistical communication and not for therapy. There may be occasions, due to unforeseen circumstances, where a telephone or video therapy session may be conducted; in these instances, confidentiality may be compromised (unless Jituzu is utilized) and cannot be guaranteed due to the electronic nature of the communication. Please initial next to each electronic method of communication that you consent to using:

Additionally, I understand that Jill Carl uses the Signal app for texting; this app uses encrypted technology for more secure texting. I understand that I can download this app and use it to communicate via text in a more HIPAA-compliant manner with Jill Carl. I also understand that I can set up a client portal through Jituzu and can email Jill Carl confidentially, as well as schedule appointments on Jituzu.

_____ Cellular/Mobile Phone

_____ Texting via Cellular/ Mobile Phone

_____ Unsecured Email

_____ Other Media. Please describe: Skype/FaceTime video session.
(Video Sessions on Jituzu are HIPAA-Compliant)

_____
Client Signature Date

_____
Jill Carl, LCSW Date

Jill Carl, LCSW
Licensed Clinical Social Worker

Insurance Authorization for Claims Submission

I authorize the release of any medical or other information necessary to process my insurance claim for mental health benefits. I also request payment of insurance to the undersigned mental health provider. However, it is understood that the client, not the client's insurance company or the client's employer. is responsible for payment of services rendered. The client is to pay copayment charges (or to pay in full if unsure of insurance benefits) at the time of each visit, unless otherwise arranged.

The undersigned agrees that in consideration of the services rendered to the patient, he/she hereby individually obligates him/herself to pay the full charges as incurred over the course of treatment, including those fees not paid by the insurance carrier. It is understood that a lack of payment may result in a referral of the account to an attorney or agency for fee collection.

_____ (please initial) It is understood that a formal mental health diagnosis must be rendered by the therapist in order for insurance companies to authorize and pay for therapy sessions. This diagnosis becomes a permanent part of your mental health and, in some cases, medical record. I am more than happy to discuss and/or go over your diagnosis before it is submitted to your insurance company, but it is your responsibility to request this.

_____ (please initial) In the event that an appointment is not cancelled twenty four hours prior to the scheduled time, a $50.00 fee will be charged. Exceptions to this include: family emergencies, unexpected illness and severe weather-related issues.

_____

Client Printed Name Signature Date

_____

Parent/Legal Guardian Printed Name Signature Date
(If Primary Client is a Minor)

_____

Jill Carl, LCSW Signature Date

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score