Laurie Carrera MSW, LICSW
9 Colonial Way
Barrington, NH 03825
603-988-5511

Hello.

I look forward to meeting you soon!

Please find enclosed all the initial paperwork. Please bring the following with you at your first appointment:

1. Completed and signed Intake forms
2. Signed Acknowledgement of Policies and Procedures form
3. Completed and Signed Notice of Privacy Practices form
4. Insurance Information and Co-Payment in full

Coming to your first appointment prepared with this paperwork will save time and is appreciated.
We are located on Route 125 next to Calef Highway Autos. We are in the same building as HBL Group and the Hearing Center. We share a waiting room with Dynamic Massage Therapy.

Please do not hesitate to call or email if you have any questions.

Thank you in advance,
Laurie Carrera, MSW, LICSW

The Barrington Counseling Center

9 Colonial Way, Barrington, NH 03825

Laurie Carrera, MSW
Licensed Independent Clinical Social Worker
603-988-5511

Intake Form

Name:	Date:
Date of Birth:	SSN#:
Street Address:	Town/City:
State:	Zip Code:
Phone:	Okay to leave a message? Yes No
Email:	Okay to email? Yes No

Parents/Legal Guardian(s):

Mother's Name:	
Address:	
Phone:	Okay to leave a message? Yes No
Email:	Okay to email? Yes No
Father's Name:	
Address:	
Phone:	Okay to leave a message? Yes No
Email:	Okay to email? Yes No
Emergency Contact:	Phone:

☐ **Yes, I have health insurance (please complete the following):**

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company:	Insurance Company:
ID #:	ID #:
Group/Div #:	Group/Div #:
Name of Insured:	Name of Insured:
Subscriber Name:	Subscriber Name:
Relation to Client:	Relation to Client:
Co-Payment:	Co-Payment:

☐ I do not have health insurance or *will not* be using my health insurance for services. I understand that I will be assessed a fee for each session.

_____ _____ _____ _____

Client Signature **Date** **Clinician Signature** **Date**

Questionnaire

Please discuss the reason(s) that you are seeking counseling at this time:

Please share what you hope to gain, achieve or overcome through counseling:

Please list any previous treatment services, including outpatient or hospitalizations:

Please discuss any family history of substance use, trauma or mental health diagnoses:

Please mention any current life stressors for you:

Please share some of your strengths, interests and activities:

Please list any current medications that you are currently taking, including dosage:

Helpful Checklist

Stressful Events During the Last Year:

- ☐ Recent Hospital Discharge
- ☐ Death/Divorce/Separation
- ☐ Relationship Problems
- ☐ Move
- ☐ Educational Problems
- ☐ Health Problems (specify:) _____
- ☐ Other:
- ☐ Housing Problems
- ☐ Access to Health Care
- ☐ Witness or victim of violence
- ☐ History/Current Abuse
- ☐ Disability (self or family member)
- ☐ Parenting Issues
- ☐ Job Loss
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Loss of a pet
- ☐ Other Family Problems

Symptoms Experienced in Last Four Weeks:

- ☐ Inattentive, distractible, off task
- ☐ Hyperactive, fidgety, excessive talking
- ☐ Impulsive, interruptive
- ☐ Forgetful, not following through
- ☐ Difficulty organizing
- ☐ Loses necessary things
- ☐ Excessive, frequent worries
- ☐ Difficulty separating from parents
- ☐ Panic attacks
- ☐ Obsessive/compulsive behaviors
- ☐ Social phobia, refuses to talk
- ☐ School refusal
- ☐ Frequent complaints of not feeling well
- ☐ Sleep problems, nightmares
- ☐ Re-enacting, re-experiencing traumas
- ☐ Avoiding or reacting to trauma triggers
- ☐ Does not show emotion
- ☐ Hyper-arousal, easily startled
- ☐ Argumentative, defiant of adults
- ☐ Angry, touchy, easily annoyed
- ☐ Deliberately annoys, spiteful
- ☐ Blames others for mistakes
- ☐ Predominately sad/depressed mood
- ☐ Predominately irritable/angry mood
- ☐ Extreme angry outbursts, crying spells
- ☐ Changes to sleep pattern
- ☐ Appetite/weight changes
- ☐ Social withdrawal, loss of interest
- ☐ Negative thinking, self-depreciation
- ☐ Thoughts of death, suicide, self-harm
- ☐ Excessively elevated mood
- ☐ Inflated self-esteem, grandiosity
- ☐ Suicidal gestures
- ☐ Socially withdrawn/isolated
- ☐ Pressured speech, flight of ideas
- ☐ Aggressive/cruel to people, animals
- ☐ Deliberate property destruction
- ☐ Lying, cheating or stealing
- ☐ Serious rule violations
- ☐ Bullies/intimidates others
- ☐ Fire setting
- ☐ Running away from home
- ☐ Wetting the bed
- ☐ Soiling
- ☐ Tic disorder
- ☐ Thoughts of wanting to hurt others
- ☐ Eating disorder
- ☐ Substance abuse
- ☐ Seeing/hearing things that aren't there
- ☐ Paranoia
- ☐ Bizarre thoughts, magical thinking
- ☐ Issues of sexuality
- ☐ Other:

Summary of Strengths:

- ☐ Good health
- ☐ Healthy nutrition/eating
- ☐ Hobbies
- ☐ Talents
- ☐ Positive attitude
- ☐ Stable living situation
- ☐ Clean, organized living space
- ☐ Money management skills
- ☐ Regular exercise
- ☐ No drug/alcohol use
- ☐ Access and use of reliable transportation
- ☐ Family support
- ☐ Adult friendships
- ☐ Peer friendships
- ☐ Interpersonal skills
- ☐ Assertive communication
- ☐ Good judgment
- ☐ Cognitive skills/ability
- ☐ Reading/writing/arithmetic skills
- ☐ Employment (if applicable)
- ☐ Part-time (less than 20hrs/week)
- ☐ Volunteer work
- ☐ After school activities
- ☐ Active use of community resources
- ☐ Active spiritual/religious life
- ☐ Motivated to make changes
- ☐ Medication follow through
- ☐ Computer skills
- ☐ Other (describe)

Family Stressors:

- ☐ Divorce/Separation in family
- ☐ Death of family member
- ☐ Financial Difficulties
- ☐ Physical abuse by adult
- ☐ Parental incarceration
- ☐ Blended Family
- ☐ Unstructured home environment
- ☐ Neglect
- ☐ Recent/Frequent moves
- ☐ Homelessness
- ☐ Sexual abuse by adult
- ☐ Sexual abuse by peer
- ☐ Parental mental illness
- ☐ Extended medical absence of parent
- ☐ Domestic violence
- ☐ Chaotic home environment
- ☐ Parental unemployment
- ☐ Psych/emotional abuse by adult
- ☐ Parental substance abuse
- ☐ Family poverty
- ☐ Other:

Family Strengths:

- ☐ Parent(s) consistently employed
- ☐ Parent aware of child's activities
- ☐ Warm/positive relationship with parent(s)
- ☐ Adult mentors available outside of immediate family
- ☐ Predictable rules, structure, routine, chores in home
- ☐ Family discipline with discussion and fairness
- ☐ Child's perception that parents care
- ☐ Monitoring of child by adults in neighborhood
- ☐ Parent(s) feel supported
- ☐ Other:

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name:_____

DOB: _____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Laurie Carrera's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Laurie Carrera at (603) 988-5511.

_____ _____

Signature of Client ***Date***

_____ _____

Signature of Parent, Guardian or Personal Representative * ***Date***

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

❑ ***Client Refuses to Acknowledge Receipt****:*

_____ _____

Signature of Clinician ***Date***

Acknowledgement and Acceptance of Office Policies and Procedure Information

My signature below indicates that I have read and understand the Office Policies and Procedure and Information document and agree to abide by its terms including:

* Code of Ethics
* Qualifications and scope of Practice
* Confidentiality
* Reporting Requirements
* Minors
* Conflicts of Interest
* Court Ordered Treatment
* Group Therapy
* Professional Boundaries
* Concerns or Complaints
* Limits of Availability
* Recommended Treatment
* Limits of Service
* Professional Records
* Insurance/Reimbursement of Services
* Electronic Communications
* Client Rights and Responsibilities

I understand that insurance co-payment or full payment is due at time of service. If you pay for services by check and your check is returned due to insufficient funds, you will be charged an additional $25.00. You will be charged the full fee amount of $110.00 if you no show an appointment or cancel with less than 24 hours of notice.

I, _____ (name), authorize Laurie Carrera, MSW, LICSW, to evaluate and treat me _____(name).

_____ _____

Printed Client Name ***Date***

_____ _____

Signature of Client ***Date***

_____ _____

Signature of Witness ***Date***