Together – Building a Bright Future

Amber Kuntz and Associates

Dietetic Intake

Name: ____________________________ Gender: ______ Date:________________

Referred by: ______________________ Age: _____ Date of Birth: _____________

Parents Names / phone / email: ____

Address: ____

Home Phone:___________________ Work / Cell Phone: ______________________

Ok to call and identify or leave message on phone and email initial: ___Yes ___ No

E-mail:__________________________

We use this information to determine how to best meet your needs. Please elaborate below.

What do you want to see a counselor / Dietitian about?

How long has this been a problem? (days, weeks, months, etc.)

How would you estimate the severity of the problem (place "X" on the line)

Mild Moderate Serious Severe

What Symptoms are related to this problem? Please check all that apply for you now?

___Overeating ___Restless ___Rapid Heart Rate
___Compulsive behaviors ___Taking Drugs ___Depressed Moods
___Sweating ___Fears /Phobias ___Odd Behaviors / thoughts
___Crying ___Trembling/ Shaking ___Anxiety
___Weight loss ___Difficult Concentrating ___Shortness of Breath
___Vomiting ___Weight Gain ___Low Motivation
___Muscle tension ___Distrust ___Social withdrawal
___Aggressive behavior ___Outburst of temper ___Jumpy
___Family Emotional Problems ___Feelings of worthlessness ___Nightmares
___Dizzy / lightheaded ___Chest pain ___Stomach problems
___Easily distracted ___Fatigue / loss of energy ___Can't fall asleep
___Sleeping too much ___Decreased need for sleep ___Obsessions
___Financial problems ___Problems with school ___Housing problems
___Relationship problems ___Experienced a traumatic event
___Pain ___Drinking alcohol ___Drugs
___Other

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Current Diagnosis and medication:____
Family Disease:
____
____

What is your eating style: (snacker, grazer, large meals, small meals, eat w/out hunger, bored eater, emotional / stressed eater, salty food, fatty food etc..) How many meals do you usually eat in a day? Any history of diuretics? Purging?
____
____
Food allergies or intolerances? Explain____

How much do you snack in a day? ____
How many ounces of fluid o you usually drink and what types?_______________________________
How many servings of vegetables do you get in a week / day? _______________________________
Explain your alcohol consumption if needed:____
How much sleep do you get in a night? How well do you sleep? Explain:

Do you get Diarrhea or constipation often? Explain:

Eating log for the last 24 hours:

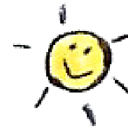
Other information:

NFORMED CONSENT

Thank you for choosing Mrs. Amber Kuntz, LPCS & Associates. Today's intake appointment will take approximately 45--70 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Amber Kuntz and Associates practice standard therapy for most conditions, although other treatment approaches are used depending on the person and/or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. It is the client's responsibility to discuss any concerns with the staff and to be aware that we are here to support and are not liable for emotional health. If there are signs of serious mental illness client should see a local psychiatrist or be assessed by a local hospital.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for a) information shared with psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this information to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and, e) if you provide information that informs me that you are in danger of harming yourself or others, f)information necessary for case supervision or consultation, g) information you and/or your child or children report about a threat to National Security or a plot of terrorism; then, by the Homeland Security Act, under the regulations and laws of the Federal Government, I am obligated to report his information to the local authorities, and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Amber Kuntz, LPCS and Associates will follow those emergency services with standard counseling and support to the client or the client's family. Amber Kuntz, LPCS and Associates keep treatment plans on clients for all practical purposes and some billing purposes. Treatment plans are kept in client's chart. I understand that Amber Kuntz, LPCS and Associates use phone and e-mail to correspond with clients, and by signing below I waive my right for her to use these means to discuss the client being my child or myself. Special Note: If Amber Kuntz, LPCS or Associates becomes incapacitated or dies, I give my consent for the person(s) designated by Amber Kuntz to be custodian of my file and to access it for me.



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COORDINATION OF TREATMENT:
It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. I release information on client Name: ____ DOB _________________________

___You may inform my physician (s) ___I decline to inform my physician

1. Physician Name: ______________________________________2. Physician Name: _______________________

Clinic / Address:____Phone:________________________

COUNSELOR'S NAME____
This is a release for both provider / counselor and physician

____________________________ _________________________ __________
Client /Parent/ Guardian Printed Name Parent/ Guardian Signature Date

Acknowledgement of Receipt of "Notice of Privacy Practices"
To be seen by Counselor, Intern, or Dietitian

Please Print out and sign this page and bring it with you to your first appointmen

I acknowledge that Amber Kuntz, LPCS, NCC, NBCCH, MS and/or Associates has given me a copy of the Privacy Notice either by web, email, US Mail, or in person, (version dated 4/14/03) as required by the federal government's HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.
The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164). This form documents that Mrs. Amber Kuntz, LPCS, NCC, MS has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you. The Notice contains basic information about:

1. How your counselor may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. Which uses and disclosures require authorization from you and which don't
3. How you may revoke an authorization you have made
4. Certain rights you have to restrict use and disclosure of PHI / counselor, to receive confidential communications
5. A list of my duties to protect the privacy of your PHI / counselor, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes
6. What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make
7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI / counselor.

FEE RATE __________ 24HR Cancellation. NO SHOW fee applies. This page documents that you have received a copy of the Notice that can be seen fully on line or where given to you in person.

____________________________ _________________________ ___________Client
/Parent/ Guardian Printed Name Parent/ Guardian Signature / Initial Date

Report of Emergency conference with Parent/Guardian **Date:**
I/We have been advised that our child appears to be in a crisis situation. I/We have also been advised that we should seek further professional consultation / help. I/We have been provided with community resource information.

____________________________ _______________________ __________
Client /Parent/ Guardian Printed Name Parent/ Guardian Signature / Initial Date

__________________________ _______________________ __________
Amber Kuntz, LPCS or Associate Amber Kuntz, LPCS or Associate Date

This page is also used as your signature page as it provides signature and initials.