Kyle Duni, MSW, LCSW

New Patient Fact Sheet

Today's Date: ___________________ Name: ____________________________________

DOB: ___________________________ SS# ______________________________________

Address: ____

Home #: ____________________________ Call OK? □ Yes □ No

Confidential voice message OK? □ Yes □ No

Cell #: ______________________________ Call OK? □ Yes □ No

Text OK? □ Yes □ No

Confidential voice message OK? □ Yes □ No

Work #: _____________________________ Call OK? □ Yes □ No

Confidential voice message OK? □ Yes □ No

Email: ________________________________ Email OK? □ Yes □ No

Information shared in emails is not confidential - therapist will only address scheduling in email

If minor: Parent/Guardian Name: ____

Parent(s)/Guardian(s) Phone #: ____

Gender (optional): □ Female □ Male □ ___________________________________

Race (optional): □ White (Non-Hispanic) □ Black/African-American (Non-Hispanic)
□ Latino/Hispanic □ Asian/Asian-American □ American Indian/Alaska Native
□ Native Hawaiian/Pacific Islander □ Other: _____________________________________

Religion (optional): _________________________

Who resides with you? (check all that apply) □ Self □ Spouse □ Significant Other □ Sibling(s)
□ Child(ren) □ Parent(s) □ Roommate(s) □ Other ____________________________________

How were you referred? □ Website □ Psychology Today □ Search Engine: ________________
□ Other Website: _____________________________ □ School □ Medical/Mental Health
Provider: ____________________________ □ Other:_________________________________

Kyle Duni, MSW, LCSW

Employment (self and/or parent(s)/guardian(s) if minor)

Occupation: ____

Occupation: ____

Occupation: ____

Highest Level of Education Completed: □ Some High School □ High School Degree □ Trade School □ Associates Degree □ Some College Coursework □ Bachelors Degree □ Some Graduate/Professional Coursework □ Graduate/Professional Degree □ Other: _______________

Are you currently enrolled in school? □ Yes □ No
If yes, where? ____
□ Middle School (Grade: _____) □ High School (Grade: _____) □ College (Year: _____) □ Graduate/Professional

Current Functioning

Current Height: _____________ Current Weight: ______________

Do you currently use alcohol? □ Yes □ No

How much do you drink each week? ____ drinks per day/week (circle one)

Do you currently use other substances? □ Yes □ No

Substance: ____

How frequently do you use this substance? _____times per day/week (circle one)

Substance: ____

How frequently do you use this substance? _____times per day/week (circle one)

Substance: ____

How frequently do you use this substance? _____times per day/week (circle one)

Have you had thoughts of ending your life in the past? □ Yes □ No

If yes, have you ever attempted to end your life? □ Yes □ No

How many times? _______________

If yes, have you ever been hospitalized for thoughts of ending your life? □ Yes □ No

How many times? _______________

Where? ____

Do you currently have thoughts of ending your life?

How frequently? ______ times per day/week (circle one)

Have you had thoughts of harming others in the past? □ Yes □ No

If yes, have you ever harmed others in the past? □ Yes □ No

How many times? _______________

If yes, have you ever been hospitalized for thoughts of harming others? □ Yes □ No

How many times? _______________

Where? ____

Do you currently have thoughts of harming others? □ Yes □ No

How frequently? ______ times per day/week (circle one)

In the past, have you engaged in self-harm behaviors? □ Yes □ No

Behaviors: ____

How frequently? ______ times per day/week (circle one)

Do you currently engage in self-harm behaviors? □ Yes □ No

Behaviors: ____

How frequently? ______ times per day/week (circle one)

In the past, have you binge eaten? □ Yes □ No

How frequently? ______ times per day/week (circle one)

Do you currently binge eat? □ Yes □ No

How frequently? ______ times per day/week (circle one)

In the past, have you purged to get rid of food? □ Yes □ No

Circle one: Vomiting/laxatives/over-exercise/other: ___________________________

How frequently? ______ times per day/week (circle one)

Do you currently purge to get rid of food? □ Yes □ No

Circle one: Vomiting/laxatives/over-exercise/other: ___________________________

How frequently? ______ times per day/week (circle one)

In the past, have you restricted your food intake? □ Yes □ No

Do you currently restrict your food intake? □ Yes □ No

Do you have any history of experiencing traumatic events? □ Yes □ No

If yes, what type of traumatic events have you experienced? ________________________
____
____
____

Treatment History

Have you received other treatment prior to your treatment with me? □ Yes □ No

If yes, indicate all that are appropriate:

□ Inpatient or Partial Hospitalization

Where: ____ Dates: _______________

Where: ____ Dates: _______________

□ Intensive Outpatient Program

Where: ____ Dates: _______________

Where: ____ Dates: _______________

□ Outpatient Program

Where: ____ Dates: _______________

Where: ____ Dates: _______________

Kyle Duni, MSW, LCSW

□ Private Therapist

Who: ____ Dates: _______________

Who: ____Dates: _______________

Who: ____Dates: _______________

Who: ____Dates: _______________

Overall, did you feel your prior treatment was helpful to you?

□ Very helpful □ Somewhat helpful □ Helpful □ Not helpful

Comments: ____

____

____

Are you currently in any other type of treatment right now? □ Yes □ No

If yes, where/with whom: ____

Why are you seeking treatment currently?

____

____

____

____

What are your current goals for your treatment?

____

____

____

____

Appointment Policy

An important part of therapy is accepting responsibility for making and keeping appointments. I make every effort to provide you with a convenient appointment time. I understand that there are times when cancellation is unavoidable, but I reserve the right to charge for "no show" appointments, appointments not rescheduled or canceled with less than 48 hours notice. If you "no show" for an appointment (in other words, if you fail to attend a scheduled appointment without any prior notice), I will first attempt to contact you using the contact information you provide me. *If I am unable to reach you after attempting to contact you using the information you provide me, and I am concerned about your safety and/or the safety of others, I will ask the police to conduct a wellness check and/or call the emergency contact information you provide me in order to ensure your safety and well-being.*

Payment

I appreciate your payment at the end of each therapy session, unless we have made other arrangements. I am a fair and reasonable person and recognize that sometimes financial stress impacts and causes disruptions. However, I reserve the right to cease treatment with you if your bill is not reasonably paid on time until your bill is paid in full. In the unlikely event that treatment is suspended or terminated, I will make appropriate recommendations to you for continuation of your care, however, it is your decision about whether or not to pursue my recommendations or pursue further or continued treatment.

Insurance

If requested, will provide you with a detailed receipt on a monthly basis that you can use to file with your insurance company. Generally, insurance companies will cover for outpatient mental health treatment. Please check with your Insurance carrier to inquire about the specifics of your Plan. If your insurance company restricts coverage, I encourage you to insist upon reasonable coverage from your company. I am dedicated to protect your confidentiality and privacy, and therefore, will not speak to an insurance claims representatives without your written permission.

I have read and understand the above written Appointment Cancellation, Payment and Insurance Policies and/or have had them explained to me. By signing and dating below, I am agreeing that I will comply with the policies.

______________________________	______________________________
Client Signature	Parent/Guardian Signature (if minor)
______________________________	______________________________
Client Name	Parent/Guardian Name (if minor)
______________________________	______________________________
Date	Date

Kyle Duni, MSW, LCSW

Release of Information: Emergency Contact

This form gives us your permission to contact the person named below in the case of an emergency. We will share information we each have concerning our contact with you so that your needs can be optimally served. Your signature at the bottom of this form represents your waiver of your right to privileged communications only with respect to the sharing of information between Kyle Duni, MSW, LCSW and the person specified below.

I hereby authorize:

____

____

____

to ______ release _______ exchange (check one) information in my client record to:

Kyle Duni, MSW, LCSW, 895 State Farm Road, Suite 403-2, Boone, NC 28607, (828) 434-6562

This information shall include:

____

____

This consent shall be valid until _____________________________(not to exceed one year).

I hereby authorize this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

______________________________	______________________________
Client Signature	Parent/Guardian Signature (if minor)
______________________________	______________________________
Client Name	Parent/Guardian Name (if minor)
______________________________	______________________________
Date	Date

Kyle Duni, MSW, LCSW

Release of Information

This form gives us your permission to contact the person or agency named below and to share information we each have concerning our contact with you so that your needs can be optimally served. Your signature at the bottom of this form represents your waiver of your right to privileged communications only with respect to the sharing of information between Kyle Duni, MSW, LCSW and the person or agency specified below.

I hereby authorize:

____

____

____

to ________release _________ exchange (check one) information in my client record to:

Kyle Duni, MSW, LCSW, 895 State Farm Road, Suite 403-2, Boone, NC 28607, (828) 434-6562

This information shall include:

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