INTAKE FORM

Name_____Date_____

Address (Incl. city & zip)_____

Phone: Home (____)_____ Work (___)_____ Cell (___)_____

Email: _____

Age_____ Date of Birth_____ Place of Birth_____

Your Social Sec.#_____

Referred to this office by: _____

Do you have Health Insurance? ( ) No ( ) Yes Carrier:_____

( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Do you live: ( ) Alone ( ) With others (indicate which applies):

( ) Spouse ( ) Partner ( ) Children ( ) Parent(s)/Relatives ( ) Friend

Number of Dependents_____

Are your parents still married? ( )yes ( )no

Mother still alive? ( ) yes ( ) no Father still alive? ( ) yes ( ) no

Number of Siblings____ List names in birth order *w/* age:
(please include and indicate any half - or step - brothers &/or sisters)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

IN CASE OF EMERGENCY, NOTIFY:

_____
(please include both name and relationship)

Address_____
street city state zip

Phone number(s): _____

Your Occupation & Current Employer: _____

_____
(please include address)

Spouse's Occupation & Current Employer: _____

_____
(please include address)

Issues/Problems for which you are seeking treatment:

( ) Stress ( ) Anxiety ( ) Depression ( ) Relationship Issues

( ) Headaches ( ) Eating/Weight ( ) Smoking ( ) Job-related

( ) Other: _____

Date problem(s) began:_____

Have you previously utilized any type of psychiatric or psychotherapy services?

( ) No ( ) Yes; previous therapist/psychiatrist: _____

Are you currently taking any prescription medication?

( ) No ( ) Yes Please list & indicate prescribing physician:

_____

Do you smoke? ( ) yes ( ) no Do you drink? ( ) yes ( ) no

How much and how often?_____

Have you ever used any other drugs? ( ) yes ( ) no

Which one(s) and under what circumstances?_____

GENERAL HEALTH INFORMATION:

Primary Physician_____ Phone No._____

1. Date of your last complete physical exam? _____
2. Is chronic pain a problem for you? ( ) yes ( ) no Location: _____

3. Please list any other specific health problems you are currently experiencing:

_____

4. How would you rate your general physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

_____

5. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

6. Please list any difficulties you experience with your appetite or eating patterns

_____

Any additional comments or information that might be relevant?

FAMILY MENTAL HEALTH HISTORY:

In the section below please indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	Family Member
Alcohol/Substance Abuse	no/yes	_____
Anxiety	no/yes	_____
Bipolar Disorder	no/yes	_____
Depression	no/yes	_____
Domestic Violence	no/yes	_____
Eating Disorders	no/yes	_____
Obesity	no/yes	_____
Obsessive Compulsive Behavior	no/yes	_____
Schizophrenia	no/yes	_____
Suicide Attempts	no/yes	_____

INSURANCE INFORMATION

A COPY OF BOTH SIDES OF YOUR INSURANCE CARD IS NECESSARY FOR ME TO BILL YOUR INSURANCE COMPANY

Primary Insurance Carrier_____

Insurance carrier's Address_____

Name of Subscriber_____

Relationship to client_____

Group Number/Name_____ Member Number_____

Authorization # (if any): _____

Secondary Insurance Carrier_____

Insurance Carrier's Address_____

Name of Subscriber_____

Relationship to client_____

Group Number/Name_____ Member Number_____

Authorization # (if any): _____

OFFICE POLICIES AND THERAPEUTIC CONTRACT

Payment for services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify the office if any problem arises during the course of your therapy regarding your ability to make timely payments.

Regarding Cancellations: Since your appointment involves my reserving time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation. The full fee will be charged for missed sessions without such 24 hour notification; patients with managed care coverage will be charged the applicable full fee or co-pay, as allowed by their insurance plan.

Client signature_____ Date_____

Responsible party signature_____
(if other than client)