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INTAKE SHEET

General Information

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ SSN: _____

Phone: (H) _____ Okay to leave messages at home? _____

(W) _____ Is it okay to call you at work? _____

(cell) _____ Best number to reach you (circle): home, work, cell

Email address: _____

Referred by: _____

Current employer, school, or other occupation: _____

Job title: _____ How long at this job? _____

Education: High school or GED completed? _____ Vocational training or certificate program? _____

Associates degree? _____ College degree? _____ Graduate degree? _____ Other? _____

Did you serve in the military? _____ If so, when? _____

Legal history relevant to mental health issues (DUI, domestic violence, etc. Please include dates):

_____

Marital Status: ____ Single ____ Partnered ____ Married ____ Divorced ____Widowed

Partner's name: _____ Length of relationship: _____

Others who live in your household: _____

Children:

Name	Date of Birth	Age	Lives Where?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact

Emergency contact: _____ Relationship: _____

Phone number(s): _____

(**Therapist Use Only. ICD-10 code:** _____)

INSURANCE, PAYMENT, and BILLING INFORMATION

Client name: _____

Please check: _____ I will be paying for counseling sessions out of pocket **OR**

_____ I will be using my health insurance to pay for sessions.

Person responsible for copayments, coinsurance, deductibles, and/or payment in full:

Name of insured: _____ Relationship to client: _____

Social Security Number: _____ Date of birth: _____

*Please provide insurance card(s) at our first appointment so that copies can be made for your file.

PRIMARY INSURANCE COMPANY: _____

Subscriber's Name_____ Date of birth: _____

Social Security Number: _____ Employer: _____

Member or policy number: _____ Group number: _____

SECONDARY INSURANCE COMPANY (if applicable): _____

Subscriber's name: _____ Date of birth: _____

Social Security Number: _____ Employer: _____

Member or policy number: _____ Group number: _____

I have called my insurance company to verify payment for mental health counseling; deductible amount and if it's been met this year; and co-payments or co-insurance that I will be paying out of pocket: Yes ____ No ____. **AUTHORIZATION NUMBER IF REQUIRED:** _____

****

Payment and Insurance billing

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company noted above. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company.

I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Client or Authorized Person's Signature: _____

Relationship To Client: _____

****

For your information: Your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.

GENERAL HEALTH INFORMATION

- Have you had counseling in the past? Yes ____ No ____. Dates: _____
  With whom? _____ Helpful? Not helpful? _____
- Psychiatrist (if you see one): _____ Phone: _____
- Previous inpatient treatment for mental health or substance abuse? ____ Yes ____ No. If yes, please provide dates, name of facility, length of stay, and what you were treated for:

  _____
- Primary care physician: _____ Phone: _____
- How would you rate your current physical health? Please circle:

  poor unsatisfactory satisfactory good very good
- Please list any specific health problems you are currently experiencing: _____

_____

- How would you rate your current sleeping habits? Please circle:

  poor unsatisfactory satisfactory good very good
- How many times per week do you generally exercise? _____. What types of exercise do you participate in? _____
- Please list any difficulties with your appetite or eating patterns: _____

_____

- Are you currently experiencing overwhelming sadness, grief, or depression? ____Yes ____ No
  If yes, for approximately how long? _____
- Are you currently experiencing anxiety, panic attacks, or have any phobias? ____Yes ____ No
  If yes, please specify which of these and when? _____
- Are you currently experiencing any chronic pain? ___Yes ____ No. If yes, please describe:

  _____

Prescribed Medications:

Name of prescription	Dosage	# times taken per day	Prescribed by	When first taken

Over-the-counter medications (including herbs, supplements or natural remedies) taken for managing symptoms (do not include vitamins): _____

_____

Allergies/adverse reactions to foods, drugs, etc.: _____

_____

(Please note: While I must ask for the information about allergies as part of a quality assurance regulation, I do not have the training to evaluate that information. Please inform your doctor or any other prescribing individual of your allergies.)

FAMILY MENTAL HEALTH HISTORY

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

			Family Member(s)
Anger	____ yes	no _____	_____
Anxiety	____ yes	no _____	_____
Depression	____ yes	no _____	_____
Domestic Violence	____ yes	no _____	_____
ADD/ADHD	____ yes	no _____	_____
Eating Disorder	____ yes	no _____	_____
Obesity	____ yes	no _____	_____
Obsessive Compulsive Behavior	____ yes	no _____	_____
Schizophrenia	____ yes	no _____	_____
Bipolar Disorder (manic depression)	____ yes	no _____	_____
Suicide Attempts	____ yes	no _____	_____
Alcohol or drug abuse, workaholism, sex addiction, spending/gambling addiction	____ yes	no _____	_____
Dementia	____ yes	no _____	_____

SUBSTANCE USE or ADDICTIVE TENDENCIES

Please check any of the following that you currently use or have used in the past:

Substance	Used in Past?	Use Now?	Problem now?	How much & how often used?
Hard Liquor	_____	_____	_____	_____
Beer/Wine	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Tobacco/Nicotine	_____	_____	_____	_____
Caffeine (coffee, tea, cola)	_____	_____	_____	_____
Speed/Meth/Amphetamines	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Mushrooms	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Heroin/Narcotics	_____	_____	_____	_____

Other addictive activities (compulsive shopping, gambling, eating, overworking, sex, gaming, TV, other — please specify): _____

_____ _____ _____ _____

SUPPORT SYSTEM

Please describe your current emotional support network, for example, partner or spouse, family members, friend(s), coworker(s), faith community or spiritual path, extracurricular activities, community organizations, pets: _____

_____

_____

AREAS OF CONCERN:

Please describe the concern or problem that led you to seek counseling: _____

_____

_____

GOAL(s) FOR COUNSELING: _____

_____

_____