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Psychotherapy Intake Information

GENERAL INFORMATION

Your Name _____ Today's Date _____

Full Address _____

Phone _____ Email _____

Please mark all ways I may contact you: Phone Text Email

Age _____ Date of Birth _____ Referred By _____

Occupation _____ Educational Level _____

Relationship Status: single married/live together separated/divorced live with parents

Spouse/Partner Name & Age _____

Partner Phone or other Emergency Contact _____

Names/Ages of Children _____

Military

Are you or your current spouse a veteran or current member of the U.S. Military/Reserves yes no

Please describe _____

FINANCIAL INFORMATION

If you want to have services billed through your insurance, please provide the information here:

Insurance Carrier _____

Primary Insured Person Name & Relationship _____

Your Member ID & Group Number _____

Primary Insured's Date of Birth _____

Authorization Number (if known) _____

Date of Authorization and # of Sessions _____

Annual Household Income _____ # People in Household _____

Sessions are a full 60 minutes at \$150.00 paid at time of session, unless other arrangements have been made and/or unless other requirements/restrictions are imposed by your insurance carrier. Insurance carriers do not pay for cancellations and no-shows. You are responsible for the full fee set by your insurance carrier for non-emergency cancellations made less than 24 hours in advance. No-shows will be billed to you at my full rate. Please initial that you understand and agree to these payment terms: _____

AREAS OF CONCERN

What concerns led you to seek treatment? _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to your treatment? _____

PSYCHOLOGICAL HISTORY

Have you ever received counseling/mental health treatment before? yes no
If yes, briefly state when and why _____

Have you ever been hospitalized for mental, emotional or addiction issues? _____

Please list any medications for a mental or emotional issue you currently take or have taken in the past:

Patient may be asked to sign an authorization for release of confidential health information so that any former or current health care provider or therapist may be contacted in order to provide relevant information to support or inform your current treatment here.

Have you ever attempted suicide? How old were you? _____
Are you currently having any suicidal thoughts? _____

Were you ever subjected to verbal, emotional, physical or sexual abuse? _____
If yes, by whom and when? _____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe:

Are you currently experiencing any medical/physical/pain symptoms that you attribute to a mental, emotional or stress-related condition? Please describe:

CURRENT STATUS

In the following two categories, please circle the best description of **how you have felt (on average) over the past two weeks:**

Very Sad/Depressed A little down Just OK Pretty OK Happy/Satisfied Elated/Excited

AND:

Severe/Constant Anxiety Worried Just OK Pretty Calm Relaxed/Satisfied Enlightened

Please feel free to include any other information that you believe is relevant to your mental health treatment:

Thank you!