

**INTAKE INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ (Can a message be left there?) Yes No

Business Phone: (\_\_\_\_) \_\_\_\_\_ (Can a message be left there?) Yes No

Cell Phone: (\_\_\_\_) \_\_\_\_\_ (Can a message be left there?) Yes No

MARITAL STATUS: \_\_\_\_\_

MARRIAGE DATE(S): \_\_\_\_\_

CHILDREN: (Please indicated from which marriage)

<u>NAME</u>	<u>AGE</u>	<u>GRADE/OCCUPATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation: \_\_\_\_\_ How Long At Present Job? \_\_\_\_\_

Business Name And Address: \_\_\_\_\_

Educational Background: \_\_\_\_\_

Religious Background: \_\_\_\_\_

Military History: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_ Physician/Phone: \_\_\_\_\_

Current Medications and Reason for Use? \_\_\_\_\_

\_\_\_\_\_

Chronic Conditions: \_\_\_\_\_

\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY (Name, relationship, address, phone number)

\_\_\_\_\_

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

	Rarely	Sometimes	Often
SLEEP DISTURBANCES	_____	_____	_____
DIFFICULTY CONCENTRATING	_____	_____	_____
FEELINGS OF WORTHLESSNESS	_____	_____	_____
FEELINGS OF GUILT	_____	_____	_____
RECURRENT THOUGHTS OF DEATH	_____	_____	_____
SUICIDAL THOUGHTS/ATTEMPTS	_____	_____	_____
SUDDEN WEIGHT LOSS OR GAIN	_____	_____	_____
FREQUENT CRYING SPELLS	_____	_____	_____
FEELINGS OF FATIGUE	_____	_____	_____
DISINTEREST IN DAILY ACTIVITIES	_____	_____	_____
FEELINGS OF ANXIETY/ PANIC	_____	_____	_____
SEXUAL DIFFICULTIES	_____	_____	_____
DIFFICULTY MAKING/KEEPING FRIENDS	_____	_____	_____
AGGRESIVE BEHAVIORS	_____	_____	_____
MOOD SWINGS	_____	_____	_____
FINANCIAL/LEGAL/ DIFFICULTIES	_____		

ADDITIONAL INFORMATION FOR CHILDREN)

	Never	Sometimes	Often
BEDWETTING	_____	_____	_____
SCHOOL PROBLEMS	_____	_____	_____
INAPPROPRIATE SEXUAL BEHAVIOR	_____	_____	_____
CLINGING/FEARFUL BEHAVIOR	_____	_____	_____
LYING/STEALING	_____	_____	_____
ACCIDENT PRONE	_____	_____	_____
LEGAL DIFFICULTIES	_____		

**HISTORY OF SUBSTANCE ABUSE**

Current (Past 6 months)

Previous

**FAMILY HISTORY OF SUBSTANCE ABUSE:**

<u>Relative</u>	<u>Substance Abused</u>
_____	_____
_____	_____
_____	_____

**HISTORY OF TRAUMA:** (Including life-altering events; physical, emotional, and/or sexual abuse)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORY OF THERAPY:** (Please give name of therapist(s), dates seen, reason for treatment, and outcome)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BRIEFLY STATE YOUR REASON(S) FOR SEEKING CONSULTATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WHAT WOULD YOU LIKE TO ACCOMPLISH DURING CONSULTATION?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **PSYCHOTHERAPIST – PATIENT SERVICES AGREEMENT**

Thank you for seeking therapy with us. Prior to your initial session, we would like to clarify our office policies and explain how therapy is conducted.

By signing this agreement you are consenting to take part in (or allow your child to receive) treatment by the mental healthcare provider named below.

### **Confidentiality**

Your therapeutic relationship is confidential. Records or information about your therapy will not be released without your written permission. However, there are certain legal limitations to confidentiality.

1. If we believe you pose a threat to your life, or the life of another person we are legally responsible for taking measures to prevent such action. This may include contacting appropriate authorities.
2. If I know, or have reason to suspect, that a child under 18 is abused, abandoned or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once a report is filed, I may be required to provide additional information.
3. If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected or exploited, the law requires that I file a report with the central abuse hotline. Once a report is filed, I may be required to provide additional information.

If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

You should be aware that I employ administrative staff. In most cases, I need to share protected information with this individual for administrative purposes, such as scheduling, billing and quality assurance. All staff members are given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.

## Office Policies and Procedures

1. Therapy sessions are 50 minutes in length. Longer sessions may be scheduled at your request.
2. Our current fee for a 50 minute therapy session is \$150.00 to \$175.00 (depending on what Doctor you are contracting with). Payment is expected at the time of the session. Payment can be made by personal check or cash (no credit cards). Fees for other services such as psychological testing will be assessed on an individual basis.
3. In case of an emergency, your therapist is available on beeper. In the event that he/she is out of town, another therapist will provide coverage.
4. Your therapist is available for brief phone contacts between sessions. However, lengthy telephone calls, consultations, and correspondence will be billed at your therapy rate.
5. There is no charge for appointments canceled at least 24 hours in advance. However, if you cancel the same day or if you fail to keep an appointment, you will be expected to pay for the missed session except in case of emergency. Our answering service will take messages on evenings and weekends.
6. We do not believe it is advantageous to expect your therapist to testify in court. This interferes with the therapeutic process. The only exception to this is if you are here originally for an evaluation regarding a legal issue. All forensic work (e.g. depositions, court testimony, court reports, research, correspondence, etc.) will be billed at 200% of your therapy rate.

Your signature below indicates that you have read and understand this agreement and agree to its terms.

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date