

INTAKE INFORMATION

Date: _____

Patient Name: _____ D.O.B. _____ Age: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

Address: _____
Street City State Zip

Cell Phone: (____) _____ (Can a message be left there?) Yes No

Business Phone: (____) _____ (Can a message be left there?) Yes No

Email Address: _____

MARITAL STATUS: _____

MARRIAGE DATE(S): _____

CHILDREN: (Please indicated from which marriage)

NAME

AGE

GRADE/OCCUPATION

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 \$200.00 if paid by check or cash, \$205.00 if paid by credit card. Payment is expected at the time of the session. Fees for evaluations will be assessed on an individual basis.
3. In case of an emergency, your therapist is available by cell phone.
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