COUNSELINGWORKS
ADOLESCENT · ADULT · COUPLES

Intake Form

Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

CLIENT INFORMATION

Name: ____SSN:___________________________

(Last) (First) (Middle Initial)

Email address: ___________________________________ Phone #:_______________________

May we email you? □ Yes □ No May we leave a message? □ Yes □ No

Birth Date: ______ /______ /______ Age: ________ Gender: _________________________

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ____

Home address: ____

(Street and Number)

____

(City) (State) (Zip)

Client employer: ___________________________________Occupation: ____________________

Referred by (if any):____

INSURANCE INFORMATION

Person responsible for this account: ____

Relationship to Patient_____________________ DOB of insured: _________________________

Insurance Provider Name: _____________________ Subscriber Name: _____________________

Subscriber Policy: _____________________________________ Group#:______________________

Customer Service Number: (back of card) ____

ADDITIONAL INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication?

□ Yes □ No

Please list: ____

____

Have you ever been prescribed psychiatric medication?

□ Yes □ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

____

2. 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:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in? ___________________________________

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

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? ____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? ____________________________________

7. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe: ____

8. Do you drink alcohol more than once a week?

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly

10. Are you currently in a romantic relationship?

□ No

□ No

□ Yes

□ Infrequently

□ Yes

□ Never

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:

____

____

____

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 in the space provided (father, grandmother, uncle, etc.).

Please Circle

List Family Member

Alcohol/Substance Abuse: yes/no

Anxiety: yes/no

Depression: yes/no

Domestic Violence: yes/no

Eating Disorders: yes/no

Obesity: yes/no

Obsessive Compulsive Behavior: yes/no

Schizophrenia: yes/no

Suicide Attempts: yes/no

RISK ASSESSMENT:

1. Any risk factors present? □ No □ Yes

If yes, specify current risk factors

Potential for violence: yes/no

Hostile/ Abusive behavior: yes/no

Major Depression: yes/no

Suicidal Ideation/Intent/Plan: yes/no

PAST RISK FACTORS

Suicide Attempts: yes/no

Violent Behavior: yes/no

Inpatient Hospitalization: yes/no

Hostile/Abusive behavior: yes/no

Major Depression: yes/no

Suicidal Ideation/Intent/Plan: yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

____

____

____

____

4. What do you consider to be some of your weaknesses?

____

____

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

____

Payment Policies and Procedures

Methods of Payment: (Please Select Your Preference)
_______ Check
_______ Cash
_______ Visa, MasterCard, Discover or AMEX

Insurance Co-Payment / Co-Insurance / Deductible

$_________ per visit

Cancellation/No Show Policy:

I agree that I will pay 100.00 for all missed appointment and appointments canceled without 24 hour notice. Initials: _________

Credit Card Authorization Request:

I authorize Counseling Works to charge my credit card for the following purposes: (When applicable)

_______ Co-payments
_______ Onetime payments on an account
_______ Any outstanding balances after date of service
_______ Charges for missed sessions or sessions which are canceled without 24-hour notice.

Name on Credit Card: ____

Type of Card: Discover Visa MasterCard

Card# _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiration Date: _ _/_ _

Security Code (last 3 #'s on back of card): __ __ __

I hereby give authorization for payment of insurance benefits to be made directly to Counseling Works for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I the event of default, I agree to pay a 30% collection fee and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Client or Authorized Person's

Signature: _______________________________________ Date:_____________