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 FATIQUE	_____	_____	_____
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:

Relative	Substance Abused
_____	_____
_____	_____
_____	_____

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 $250.00 if paid by check, cash, Zelle or Venmo, $260.00 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