INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Today's Date:_____

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Married □ Separated □ Divorced □ Widowed

Address: _____

(Street)

_____

(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell Phone: _____ May we leave a message? □Yes □No

Please list any children/age: _____

Preference for delivery method of appointment reminders:
□ E-mail*: _____
□ Text Message
□ Voice Mail (must be delivered to a land line) _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Emergency contact name:_____

Phone number:_____ Relationship:_____

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 do 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? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

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:

_____

_____

_____

12. Anything else you want me to know:

_____

_____

_____

_____

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	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes □ F/T Student □ P/T Student

If yes, who is your current employer:

_____

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:

_____

INSURANCE INFORMATION

IF YOU ELECT **NOT** TO UTILIZE YOUR INSURANCE BENEFITS, YOU ACKNOWLEDGE THAT YOU ARE WAIVING THE RIGHT TO FILE FOR ANY SERVICES FROM THIS POINT FORWARD AND THAT NO CLAIMS WILL BE FILED RETROACTIVELY. YOU RETAIN THE RIGHT TO CHANGE YOUR DECISION AND BEGIN TO USE YOUR BENEFIT AT ANY TIME. CLAIMS WILL ONLY BE FILED GOING FORWARD FROM THE POINT AT WHICH YOU DECIDE TO UTILIZE INSURANCE BENEFITS.
My signature below indicates that I have read and understand the notification above:

_____
Printed Name

_____
Signature (or enter N/A) that you understand and agree to the statement above.

Please complete the following information if you plan to utilize health insurance benefits.

Insurance Company: _____

Phone: _____ ID#:_____

Claims Address: _____

Policy Holder (if different than client):_____

Address (if different than client):_____

_____ Date of Birth: _____

Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other □ M □ F

Is this insurance an employer group policy? □ Yes □ No

If yes, what is employer's name? _____

Group #: _____

PLEASE READ AND SIGN THE FOLLOWING:

ASSIGNMENT OF BENEFITS

I authorize Michael W. Sessions, PhD to release to my insurance company or other third-party payer any information necessary for the processing of insurance claims. Information that may be requested includes type of service, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries. I authorize payment of medical benefits to Michael W. Sessions, PhD for services rendered. I accept personal responsibility for any balance remaining for services rendered, including those that may be determined "not medically necessary" by my insurance company.

_____ _____
Signature of Client or Parent/Guardian Date