INITIAL MENTAL HEALTH INTAKE FORM

Please fill out this entire page and send back to me prior to your first session.
*NOTE – I cannot meet with you until this form is filled out and signed.

Name: _____
(First) (MI) (Last)
nickname or preferred name: _____
Birth Date: _____ /_____ /_____ Age: _____
Gender: □ Male □ Female □ Other (if other, preferred pronouns: _____)
Marital Status: □ Never Married □ Partnered □ Married □ Divorced □ Widowed
Number of Children: _____ Ages & Names of Children: _____
Local Address: _____
Phone: ( ) E-mail: _____
Referred by: _____
Are you currently receiving psychiatric services or professional counseling elsewhere? □ Yes □ No
If yes, Doctor or Professional's name _____
Have you had previous psychotherapy? □No □Yes - Previous therapist's name_____
Are you currently taking psychiatric medication? □No □Yes If Yes, please list:
_____
If no, have you previously taken psychiatric medication? □No □Yes If Yes, please list:
_____
Have you ever been hospitalized for psychiatric purposes? □No □Yes If yes, please explain:
_____
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____
Are you having any problems with your sleep habits? □No □Yes If yes, check where applicable: □ Sleeping less □ Sleeping more □ Trouble falling asleep □ Trouble staying asleep
How many times per week do you exercise? _____
Are you having any difficulty with appetite or eating habits? □No □Yes If yes, check where applicable: □ Eating less □ Eating more □ Binge eating
How often do you use alcohol? _____
How often do you engage in recreational drug use? _____
Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never
Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
If you are married, how long have you been married? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____
In the past 1-3 years, please list any significant life changes or stressors: _____
Have you ever experienced:
Extreme depressed mood yes/no
Wild Mood Swings yes/no
Rapid Speech yes/no

Extreme Anxiety yes/no
Panic Attacks yes/no
Phobias yes/no
Sleep Disturbances yes/no
Hallucinations yes/no
Unexplained losses of time yes/no
Unexplained memory lapses yes/no
Alcohol/Substance Abuse yes/no
Frequent Body Complaints yes/no
Eating Disorder yes/no
Body Image Problems yes/no
Repetitive Thoughts (e.g., Obsessions) yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no
Homicidal Thoughts yes/no
Suicide Attempt yes/no

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list work-related stressors, if any: _____

Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith?
_____
If no, do you consider yourself to be spiritual? □ No □ Yes
Have you ever been convicted of a crime? □ No □ Yes - If yes, Please explain
_____
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):
Depression yes/no
Bipolar Disorder yes/no
Anxiety Disorders yes/no
Schizophrenia yes/no
Alcohol/Substance Abuse yes/no
Eating Disorders yes/no
Learning Disabilities yes/no
Suicide Attempts yes/no

On a scale of 1-10, how would you rate your self-esteem currently? _____
What do you consider to be your strengths? _____
What are effective coping strategies you use? _____
What are some areas you'd like to improve? _____
Please list 3 therapeutic goals:

1) _____ 2) _____ 3) _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ **Client Signature**

_____ **Today's Date**

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client in need and you will be billed for the entire cost of your missed appointment. **A full fee is charged for missed appointments or no show cancellations with less than 48 hours notice** unless there is a proven emergency.

Credit Card Type: Visa/Mastercard/Discover/American Express

Account number: ____ ____ ____ ____

Exp Date:

Security Code:

Zip code:

_____ **Client Signature**

_____ **Today's Date**

NOTICE OF PRIVACY PRACTICES

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am required by law to keep your information private. How I use and disclose your protected health information is with your consent (with the exception of The Limits of Confidentiality above). I will use the information I collect about you mainly to provide you with treatment, to arrange payment for services, and for some other business activities that are called, in the law, health care operations. After you have read this notice I will ask you to sign a consent form to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information:

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing. You must also tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.