INTAKE FORM

Thank you for completing this intake form. It will help me to be most efficient in our first session and guide the types of questions I need to ask to access your current situation and help us develop a working relationship. Please feel free to ask any questions you might have regarding the nature of therapy and/or to share your expectations and goals.

DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS:_____

_____

HOME PHONE:_____ SSN#:_____

_____MARRIED ____NEVER MARRIED

_____DIVORCED _____WIDOWED

INDIVIDUALS UNDER 18:

NAME(S) OF PARENTS/GUARDIANS, THEIR ADDRESSES AND PHONE NUMBERS:

_____

_____

_____

SPOUSE/SIGNIFICANT OTHER'S NAME:_____

THEIR SSN#:_____

THEIR DATE OF BIRTH_____

ADDRESS (if different):_____

_____

CHILDREN: Name Birthdate Biological Adopted Other

_____

_____

_____

_____

IN CASE OF EMERGENCY CONTACT: Name_____

Address:_____

_____Phone:_____

EMPLOYMENT: Employer:_____

Address:_____

May you be contacted at work? ____yes ____no

Work Phone:_____

Spouse/Significant Other's Employer:_____

Address:_____Phone:_____

HEALTH INFORMATION:

Family Physician_____
(Name) (Address)

Are you on medication now or recently?_____ If yes, type of

medication and reason for taking it?_____

_____

Significant health problems:_____

Last physical exam:_____Present health (good, poor, average)

Previous therapy/counseling? _____ If yes, name of therapist or

agency and dates of treatment:_____

Psychiatric or psychological hospitalization (where and when)____

_____

Who referred you? _____

CURRENT SITUATION: Please describe your current

concerns/situation:_____

_____

Please circle any of the following problems that pertain to you currently:

Nervousness	**Temper**	**Self-Control**
Shyness	**Children**	**Stress**
Separation	**Bowel Troubles**	**Headaches**
Drug Use	**Family**	**Memory**
Anger	**Sexual Abuse**	**Relaxation**
Inferiority Feelings	**Making decisions**	**Secrets**
Career Choices	**Physical Abuse**	**Nightmares**
Legal matters	**Depression**	**Phobias**
Too much energy	**Sexual Problems**	**Being a Parent**
Loneliness	**Divorce**	**Moodiness**
Education	**Alcohol Use**	**Unhappiness**
Feelings of guilt/shame	**Stomach Trouble**	**Marriage**
Relationship w/ food	**Lying**	**Work**
Fears	**Tiredness**	**Ambition**
Suicidal Thoughts	**Finances**	**Relationships**
Troublesome Thoughts	**Gambling**	**Conflict**
Urge to repeat actions	**Concentration**	**Grief Issues**
Lack of assertiveness	**Family of Origin**	**Sleep**

PREVIOUS HISTORY

Women Only: Please explain

Gynecological problems:_____

Previous miscarriages/stillbirths:_____

Abortions:_____

Sexual/Sexuality concerns:_____

Men Only: Please explain

Impotence_____

Premature ejaculation_____

Sexual/Sexuality concerns:_____

FAMILY OF ORIGIN Age Deceased/Year Cause of Death

Father_____

Mother_____

Stepfather_____

Stepmother_____

Siblings_____

_____

_____

Please list any family member with the following:

Depression:_____

Alcoholism/Drug Use:_____

Eating Disorder:_____

Chronic Physical Illness:_____

Chronic Mental Illness:_____

Other (please specify):_____

Insurance Information:

*****Prior to your first appointment please call your insurance company to confirm your mental health coverage. They may ask about my credentials and you can tell them I am a licensed psychologist in the State of Indiana with a Ph.D and a Health Services Provider in Psychology and an out of network provider since I am not on any insurance panels. Please confirm which address you need to send claims for processing. Sometimes medical claims are processed in a different location/office than mental health claims so this verification is necessary so your claims for counseling services will be processed in a timely manner. I need this information in case the insurance company calls me to ask questions about a claim you have filed. Your signature below gives me permission to speak to your insurance company to help process your claim.**

_____

Signature and Date

Name of Insurance Company:_____

Address:_____

Phone:_____

Contract/Group/ID Number:_____

If you are not the insured listed on the insurance card, can you please list below the insured's name, date of birth and social security number below in case I need this information when speaking to the insurance company:

Name:_____

Date of Birth:_____

Social Security Number#:_____

Employer's Name:_____

*****PLEASE BRING A XEROXED COPY OF BOTH SIDES OF YOUR INSURANCE CARD TO YOUR FIRST APPOINTMENT**

Revised 8/22/19