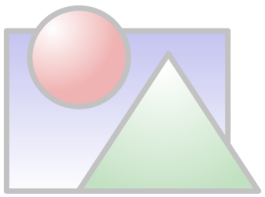
Client Intake



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Phone: 919-619-1498
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Date:

◯ **New** ◯ **Revised**

Patient Last Name

Patient First Name **MI**

Address

City **State**

Zip Code

Home Phone

Cell Phone

Work Phone

Gender

◯ **Male** ◯ **Female**

Date of Birth **SS Number**

Person to Notify in Case of Emergency

Name

Address

State/Province

Zip/Postal Code

Home Phone

Work Phone

Cell Phone

Relationship to Patient

Employment and/or Student Status (If applicable)

Employer:

Type of Employment

◯ **Full-Time**

◯ **Part-time**

◯ **Not Working**

School:

Student Status

◯ **Full-Time**

◯ **Part-Time**

◯ **Not a Student**

Marital Status

◯ **Married**

◯ **Single**

◯ **Seperated**

◯ **Divorced**

◯ **Widowed**

If Applicable, list all dependants

Name	Relationship	Birth Date

Insurance Information:
The Following Information Must Be Completed For Correct Billing.

***Please present your insurance card to therapist to be photocopied at time of first appointment.**

Primary Insurance Company

Managed Care Company

Claims Address

State/Province

Zip/Postal Code

Policy Number of Patient

Group Number of Patient

Insurance Company Telephone Number

Insurance Special Instructions or Other important Insurance Information Necessary for Filing a Claim:

Is Pre-Certification Necessary? (If you are not sure, please call your carrier for protocol)

◯ **Yes**

◯ **No**

If Yes, Certification #

Number of Visits Allowed

Start

End

Policy Holder Information:
(Must Match Policy Number of Patient)

Name of Policy Holder

Policy Holder's Policy Number

Policy Holder's Group Number

Policy Holder's Relationship to Client

Policy Holder's Address

City

State

Zip Code

Home Phone

Cell Phone

Work Phone

Policy Holder's Date of Birth

Supplemental Information:

Patient Last Name

Patient First Name

Medical History:

Please list any significant childhood illnesses:

Please list any surgeries and when they were performed:

Have you ever had a seizure, head trauma or loss of consciousness? If so, please describe:

Have you ever a CT scan, EEG or MRI ? If so, please describe:

Have you ever been hospitzalized? If so, please describe:

Have you ever been seen in the emergency room? If so, please describe:

If female, do you have a regular menstrual cycle?

◯ **Yes**

◯ **No**

Date of last physical exam:

Is your vision within normal limits?

◯ **Yes**

◯ **No**

Is your hearing within normal limits?

◯ **Yes**

◯ **No**

Please list any medication and doses you are taking currently, including over-the-counter medication, herbal medication and vitamins:

Are you allergic to any medication? If so, please list the medication and the reaction:

Family History:

Please list any blood relative with the following: ***(Please specify whether on maternal or paternal side of family)***

Substance abuse:	
Attention deficit:	
Learning problems or mental retardation:	
Depression:	
Bipolar disorder (manic depression):	
Schizophrenia:	
Autism:	
Obsessions/Compulsions:	
Panic:	
Eating disorders:	
Other anxiety:	
Suicide:	
Diabetes:	
Cancer (specify type):	
Hypertension or heart disease:	
Thyroid disease:	
Liver disease:	
Kidney disease:	
Tics:	
Genetic syndromes (please specify):	
Neurologic disorders (Parkinson's, Multiple Sclerosis, Alzheimer's, etc.):	
Epilepsy:	

Social History:

Please list name, relationship and ages of all persons living in your home:

Name	Relationship	Birth Date or Age

How do you do socially?

List any recreational activities:

List any legal issues:

Do you do any recreational drugs or alcohol? If so, please estimate frequency and quantity of use:

Previous Treatment:

Is this your first mental health consultation?

◯ **Yes**

◯ **No**

If not, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

Previous medication trials (name of medication, dose, how long the medication was taken)
Note: if uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

Previous psychiatric hospitalizations (hospital name, date of hospitalization, treatment recieved during hospitalization):

Thank you. All information will remain strictly confidential.