New Patient Intake/History Questionnaire

Welcome! We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

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

DEMOGRAPHICS

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____
(Street and Number)

_____
(City) (State) (County) (Zip code)

Home Phone: ( ) _____ May we leave a message? ☐Yes ☐No

Cell/Other Phone: ( ) _____ May we leave a message? ☐Yes ☐No

Education (grade completed, any postsecondary): _____

Current Occupation: _____

Person to alert in the event of medical emergency: _____

Relationship to you: _____ Phone: _____

Family Doctor: _____ Phone: _____

Spouse/partner's name: _____ Age: ___ Yrs in relationship: _____

Children (gender, age): _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please describe any significant current or past medical problems: _____

_____

9332 Annapolis Rd, Ste 309
Lanham, MD 20706
301-710-9400 (phone)
1-888-816-6466 (efax)

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

Have you previously received any type of mental health services (psychotherapy, psychological, psychiatric care, etc.)? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please give the dates and the nature of the difficulty at the time: _____

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:

How many times per week do you generally exercise? _____

List the types of exercise you participate in _____

_____

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:

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐Yes ☐No

If yes, for approximately how long? _____

Are you currently experience anxiety, panic attacks, or have any phobias? ☐Yes ☐No

If yes, when did you begin experiencing this? _____

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 (i.e. father, mother, grandmother, uncle, etc.)

		List Family member
Alcohol	☐Yes ☐No	_____
Substance abuse	☐Yes ☐No	_____
Depression	☐Yes ☐No	_____
Eating Disorder	☐Yes ☐No	_____
Obesity	☐Yes ☐No	_____
Obsessive Compulsive	☐Yes ☐No	_____
Schizophrenia	☐Yes ☐No	_____
Suicide attempts	☐Yes ☐No	_____

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

_____

_____

_____

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

CONSENT TO TREATMENT/CONFIDENTIALITY AND OFFICE POLICIES

In compliance with national standards of ethics, below is the required disclosure of all billing and financial matters regarding psychotherapy services. You (the individual, couple, or family), as the client(s), acknowledges that you understand the following:

RATES

The rates for psychotherapy services are typical ranges between $110 to $150 per session, depending on session length, income level, and the client's ability to pay for therapy. Payment for all psychotherapy services is due at the beginning of each session. A charge of $35.00 applies for returned checks, and in such an event a client will be asked to pay by another payment method other than by check. Forms of accepted payment include: cash, personal check, and credit/debit card. The only insurances accepted at this time is Maryland Medicaid, Carefirst BCBS PPO and HMO, and Magellan Behavior Healthcare..

You will be billed for non-covered services that are not therapist initiated, including but not limited to telephone consultation, crisis intervention, report writing, and care coordination with other providers (for example, primary care physicians and psychiatrists) at a rate of $2.50 per minute in excess of five (5) minutes. Care coordination initiated by the therapist at the beginning of therapy is a customary practice and does not carry with it a fee as it is considered a covered service. Any legal reporting, consultation, deposition/court appearance, or coordination will be billed at a rate of $2.50 per minute.

The financial status of your account will be reviewed with you periodically, if the need arises, to address questions or concerns you or the therapist may have regarding reimbursement issues involving third-party payers and balances which are due to the therapist. Any balances due, are due at the time of service (copayments, coinsurances and deductibles). Any unpaid balances over 60 days, maybe subject to a 1.5% per month interest charge. Balances beyond 90 days, we reserve the right to submit to a third party collection agency to secure payment. If your account is sent to collections, you will be responsible for the collection agency fee of 35% plus the balance that is owed. You agree to accept full responsibility for charges once these limitations have been reached and you further understand that you are financially responsible for ALL charges whether or not paid by my insurance company.

NO SHOW/LATE CANCELLATION

A missed appointment is an inconvenience to this provider and someone else that may have needed that time. I require 24 hour advance notice, for schedule changes, which includes cancellations and reschedules. If you fail to keep a scheduled appointment or cancel the same day, you will be charged a **$65.00** fee. This fee will be waived in the cases of an extreme emergency or inclement weather. ***Please note that your insurance company will NOT pay for this fee, so please do not ask me to bill this to them. This fee must be paid prior to your next scheduled appointment or within 2 weeks, whichever should come first.*** **Three (3) late cancels and/or no shows may result in the termination of services.**

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. This therapist also requires the consent of both parents prior to treating a child.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

NOTICE OF PRIVACY PRACTICES (EFFECTIVE MARCH 26, 2013) SUMMARY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Dianna McFarlane and Patrician Services, the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this therapist has the right to change its Notice of Privacy Practices from time to time and that I may contact this counselor at any time at the address(s) listed to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this counselor restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the counselor is not required to agree to my requested restrictions, but if the counselor does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

By signing below, I agree to the above policies in relationship to receiving services from this provider and understands the limits to confidentiality, its meanings and ramifications.

_____

Client Signature

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

ADULT SELF-REPORT FORM

Chief Concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

_____

Your medical care (From whom or where do you get your medical care?)

Clinic name: _____

Phone: _____

Doctor's name: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer: _____

Work phone: _____

Address: _____

Occupation: _____

Length of time with this employer: _____

Please indicate any restrictions on calls: _____

Present relationships

How do you get along with your spouse or partner? _____

_____

How do you get along with your children? _____

_____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? (please circle) Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings

insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life: (Please circle)

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:
c1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe: _____

_____

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed. (*Add additional information on back of page)* _____