PSYCHOTHERAPY INTAKE FORM

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Date: _____

Name: _____

Address: _____

City:_____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Work Phone: _____ Fax: _____

Date of Birth: _____ Age: _____

Referred by: _____

Emergency Contact: _____Phone: _____

Primary Health Care Provider:_____

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Office Use only:

CPT: _____ DX: _____

Billing Dates_____

_____

The following information can be answered as fully or briefly as you wish.

What is the reason for your visit?

What questions or concerns would you like addressed during your first visit?

Please list any major illnesses, injuries, surgeries or hospitalizations

Does your medical history include any of the following (please <u>underline</u> all that apply)

Migraines
High Blood Pressure
Stroke
High Cholesterol
Heart Attack
Easy Bruising
Blood Clots
Anemia
Indigestion
Frequent Nausea or Vomiting
Diabetes
Thyroid
Asthma
Arthritis
Back pain
Seizures
Macular Degeneration
Cataracts

Colitis
Diarrhea
Constipation
Bloody or Black Stools
Hepatitis
Liver Disease
Gallbladder Disease
Breast Biopsies
Endometriosis
Fibroids
Teeth or Gum Problems
Frequent Falling
Losing Height
Broken Bones
Weight
Cancer
Infertility
Suicidal Thoughts

Other…_____

Date of last Chemistry Panel: (blood work?)_____ Colonoscopy: _____

Family History:

Please list family member(s) who have the following…

High blood pressure	**Heart attack**
Stroke	**Blood clots**
Glaucoma	**Diabetes**
Osteoporosis	**Hip fracture**
Breast cancer	**Ovarian cancer**
Colorectal cancer	**Alzheimer's / Dementia**
Depression	**Alcoholism**
Prostrate cancer	**Drug addiction**

Is there anything about your family's health history that you would like to discuss?

Please list all medications and supplements (over the counter) you are currently taking…

NAME	DOSE	FREQUENCY	HOW LONG

Are you allergic to any medications? _____ If yes please list which ones and your reaction...

Do you have any other allergies? _____ If yes please indicate to what, and your reaction…

Do you exercise?_____ How often? _____

What do you do?_____

Do you consider your diet excellent_____ good _____ fair _____ poor _____

Please explain…

Do you smoke cigarettes?_____ How many per day _____ Do you want to quit _____

Please explain…

Do you drink alcohol? _____ How many drinks each week? _____Each day?_____

Do you feel a need to cut down on you drinking_____ _____

Please explain…

Do you use recreational drugs?_____

Please explain

Within the last year have you experienced emotional, physical or sexual abuse? _____

What are your current major stressors or life changes?_____

Any major changes in family health in the past year?_____

How do you handle stress? _____

What do you do to relax? _____

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Limits of Confidentiality Statement

Whatever we talk about, I will hold in strictest confidence. There are some legal exceptions to this:

- If you authorize a release of information with a signature.
- If your mental condition becomes an issue in a law suit.
- If you present as a physical danger to yourself (Johnson v county of Los Angeles, 1983)
- If you present as a danger to others (Tarasoff v Regents of University of California, 1967)
- If child or elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes)

In the latter two cases, I am required by law to inform potential victims, protective agencies, and/or legal authorities so that protective measures may be taken.

Payment for Services

Payments are due and payable at each appointment. If you plan to utilize your insurance benefits, you are responsible for obtaining prior authorization for treatment. SUPER BILLS WILL BE PROVIDED AT THE END OF EACH MONTH FOR SUBMISSION TO YOUR HEALTH INSURANCE COMPANIES.

Cancellation & Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If you miss or cancel an appointment with less than 24 hours notice, you will be responsible for the fee. Your insurance will not be billed for fees associated with missed or cancelled appointments.

Prescriptions and Refills

Refills can be handled by fax. Pleas allow 3 days for all refill requests. When you have a week remaining on your prescription, contact your pharmacy and request a refill. If you are not current with your appointments, refill requests may be denied.

Signature_____ **Date** _____