ADULT PATIENT INTAKE FORM

PATIENT INFORMATION

Full Name (First, MI, Last):_____ Sex: Male___ Female___

Address:_____ Birthdate:_____

City:_____ State:_____ Zip:_____ Soc. Sec.#_____-___-____

Home Phone: _____ Cell:_____ Work:_____

Email:_____

RESPONSIBLE PARTY (If Minor) OR EMERGENCY CONTACT

Full Name:_____ Home Phone:_____

Address:_____ Cell or Work Phone:_____

City: _____ State:_____ Zip:_____

Relationship to Patient:_____

How did you find Dr. Ward? (Phonebook, Website, Friend/Family, Referred, Other)

If referred, by whom?_____

GENERAL INSURANCE INFORMATION

Marital Status: _____ Employment Status: _____

INSURANCE COMPANY INFORMATION – POLICY HOLDER

First Name:_____ MI:_____ Last Name:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip:_____ Work/Cell Phone:_____

Birthdate:_____ SS#:_____-____-_____ Sex: Male____ Female____

What is your relationship to the policy holder? Spouse____ Child_____ Self_____ Other_____

Employers Name:_____ Is this your employer's health plan? Yes____ No____

Is your signature on file?_____ Will this be covered by an EAP program? Yes____ No____

EAP contact name:_____. What is your EAP Authorization Number?_____

If there is another Health Benefit Plan, please complete another intake form and write "Secondary Insurer" on the top of the form.

AUTHORIZATION SIGNATURES (insured's or other authorized persons)

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below.

I authorize payment of medical benefits to the undersigned physician or supplier for services.

Signed:_____ Date:_____ Signed:_____ Date:_____

Please Complete This Form as Thoroughly as Possible

BASIC BACKGROUND INFORMATION

Marital Status:

___ Married ____ Cohabiting ___ Divorced ___ Separated ___ Widowed ___Single

Children (name and age):_____

Persons living in your home:_____

Religious affiliation:_____ Active in Faith? _Y/N_ Military Experience _____

Work Status:_____ Type of work:_____

Education: Highest Grade Completed _____ Degree:_____ Other:_____

COUNSELING HISTORY, NEEDS, AND GOALS

If you have had previous counseling experience, please explain below:

Locations:_____ When?_____ How long?_____ Helpful?_Y__N_

Please briefly explain your reasons for seeking help NOW:

_____

_____

Are you currently having suicidal or homicidal thoughts? _Y_N_ If yes, please describe:

_____

Have you ever made a suicide attempt? _Y_N_ If yes, explain when and how:

_____

Has anyone related to you attempted homicide or suicide? _Y_N_ If yes, please explain:

_____

Do you worry about your safety in your current living situation? _Y_N_ If yes, please explain:

_____

Have you ever struck or threatened people, animals, or have you damaged property in anger?

If so, please explain:_____

Clinician Note (Office use only)

_____
_____
_____
_____
_____
_____
_____

Please check the following words that apply to you:

- ○ Social/outgoing
- ○ Intelligent
- ○ Self-Controlled
- ○ Resourceful
- ○ Creative
- ○ Can forgive
- ○ Can ask for help
- ○ Can express feelings
- ○ Stable
- ○ Secure
- ○ Faithful
- ○ Physically active
- ○ Motivated
- ○ Happy
- ○ Confident
- ○ Assertive
- ○ Not easily depressed
- ○ Mostly able to relax
- ○ Liked by others
- ○ Patient
- ○ Respect others
- ○ Perfectionist
- ○ Have enough money
- ○ Can accept love from others
- ○ Worthwhile/ "good enough"
- ○ Shy/backward
- ○ Stupid/dumb
- ○ Impulsive
- ○ Out of control
- ○ Can't concentrate
- ○ Unimaginative
- ○ Full of hate
- ○ Isolated/loner
- ○ Bottled up
- ○ Unstable
- ○ Insecure
- ○ Unfaithful
- ○ Lazy
- ○ Unmotivated
- ○ Depressed
- ○ Passive "pushover"
- ○ Easily discouraged
- ○ Tense most of time
- ○ Not liked by others
- ○ Impatient/edgy
- ○ Disrespectful
- ○ Financially stressed
- ○ Worthless
- ○ Unattractive

Other Descriptors:

_____

_____

_____

_____

_____

_____

_____

Please check any of following events you have experienced in the last year:

- ○ Death of spouse or child
- ○ Death of a close friend
- ○ Death of a close family member
- ○ Divorce
- ○ Marital Separation
- ○ Detention in jail or other institution
- ○ Major personal injury or illness
- ○ Marriage
- ○ Being fired from work
- ○ Marital reconciliation
- ○ Retirement
- ○ Major change in health or behavior of family member
- ○ Pregnancy of spouse/partner
- ○ Sexual difficulties
- ○ Gaining a new family member (e.g. birth)
- ○ Major business readjustment (e.g. merger)
- ○ Major change in financial state (better or worse)
- ○ Changing to a different type of work
- ○ Major change in the number of arguments with spouse (e.g. a lot more or less)
- ○ Taking on a significant (to you) mortgage
- ○ Foreclosure on a mortgage or loan
- ○ Major change in responsibility at work (e.g. promotion, transfer, demotion)
- ○ Son or daughter leaving home
- ○ In-law troubles
- ○ Outstanding personal achievement
- ○ Work status change for partner
- ○ Beginning or ceasing formal schooling
- ○ Major change in living conditions
- ○ Change of personal habits (dress, manners, association etc)
- ○ Troubles with the boss
- ○ Change in residence
- ○ Changing to a new school
- ○ Major change in usual type and/or amount of recreation
- ○ Major change in church or spiritual activities (more or less than usual)
- ○ Major change in social activities
- ○ Taking on a small loan (e.g. purchasing car)
- ○ Major change in sleeping habits (a lot more or less)
- ○ Major change in number of family get-togethers (a lot more or less)
- ○ Major change in eating habits (a lot more or less food intake)
- ○ Holiday or vacation
- ○ Christmas
- ○ Minor violations of the law

Please check any of the following issues you are currently having:

- ○ Custody issues
- ○ Behavior of adult children
- ○ Health problems in the family
- ○ Personal health problems
- ○ Substance abuse/dependence
- ○ Excessive computer use
- ○ Problems with pornography
- ○ Interpersonal problems
- ○ Infidelity/unfaithful partner
- ○ Distance from loved one
- ○ Gambling
- ○ Anger problems
- ○ Parenting problems
- ○ School problems
- ○ Victim of physical abuse
- ○ Victim of sexual abuse
- ○ Anxiety
- ○ Depression
- ○ Financial difficulty
- ○ Grief
- ○ Family relationships

Please check any of the symptoms that apply to you:

Physical

- ○ Headaches
- ○ Bowel/stomach
- ○ No appetite
- ○ Dizziness
- ○ Tremors
- ○ Muscle weakness
- ○ Fainting spells
- ○ Shortness of breath
- ○ Hair, skin problems
- ○ Jaw pain
- ○ Reproductive problem
- ○ Sexual problems
- ○ Excessive sweating
- ○ Heart problems
- ○ Heart races/pounds
- ○ Nausea
- ○ Fatigue

Other Symptoms:

_____

_____

_____

Emotional

- ○ Sadness
- ○ Worry
- ○ Overexcited
- ○ Agitated
- ○ panicky
- ○ Nervous
- ○ Empty
- ○ Grieving
- ○ Despair
- ○ Hopelessness
- ○ Fits of rage
- ○ Jealousy
- ○ Moodiness
- ○ Desire to cry
- ○ Resentment
- ○ Frustration
- ○ Inadequacy

Other Symptoms:

_____

_____

_____

Thoughts

- ○ Memory problems
- ○ Paranoia
- ○ Confusion
- ○ Repetitive thoughts
- ○ Racing thoughts
- ○ Attention problems
- ○ Thoughts of escape
- ○ Decision problems
- ○ Poor judgment
- ○ Hallucinations
- ○ Disorganized thinking

Other Symptoms:

_____

_____

_____

_____

_____

_____

_____

_____

Behaviors

- ○ Using drugs or alcohol more
- ○ Avoiding loved ones
- ○ Missing work or school
- ○ Laugh/cry inappropriately
- ○ Nervous habits (e.g. bites nails)
- ○ Losing temper
- ○ Becoming violent
- ○ Risky behaviors
- ○ Grind teeth
- ○ Less or more sexual contact
- ○ Less or more sleeping

Other Symptoms:

_____

_____

_____

Please explain what you have done to cope with the symptoms and issues you have checked above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Please list length of Marriage(s) / Live-ins:_____

Please describe your family of origin (name and ages of parents, siblings): _____

_____

Have you experienced any traumatic events or significant losses?_____

_____

Please describe any significant legal history (e.g. arrests, convictions, bankruptcy):_____

_____

MEDICAL HISTORY

Family Physician:_____ Date of last examination:_____

Please check any illness you have, or had in the past:

- ○ Diabetes Type I or II
- ○ Asthma
- ○ Arthritis
- ○ Pneumonia
- ○ Anemia
- ○ Ulcer
- ○ Seizures
- ○ Alcohol/drug problems
- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart disease
- ○ Thyroid disease
- ○ Tuberculosis
- ○ Colitis
- ○ Nerve disorder
- ○ Lung disease
- ○ Cancer
- ○ Kidney disease
- ○ Hepatitis
- ○ Cirrhosis
- ○ Bone disorder
- ○ Anorexia
- ○ Venereal disease
- ○ Head injuiries
- ○ Injuries
- ○ Muscular disorder
- ○ Obesity
- ○ AIDS/HIV
- ○ Fibromyalgia
- ○ Other:_____

Is there any history of depression, mental illness or alcohol/drug problems in your family of origin? ϑ Yes ϑ No If yes, please explain:_____

_____

Current prescribed medications Dose & Dates Purpose Side effects

_____

_____

_____

_____

Current over-the-counter meds Dose & Dates Purpose Side effects

_____

_____

_____

Are you allergic to any medications or drugs? ___ Yes _____ No_____

If Yes, describe: _____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Please answer YES or NO to the following four questions:

1. Have you ever thought about cutting back on your alcohol/substance use? _____
2. Have you ever been annoyed at others' comments about alcohol/substance use? _____
3. Have you ever felt guilty about your level of alcohol/substance use? _____
4. Have you ever used alcohol/substances first thing in the morning to steady your nerves or get rid of a hangover? _____

Who or what has helped you in stopping or limiting your use? _____

Clinician Note (Office use only)

_____

_____

_____

_____

_____

_____

_____

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to email, cell phone text, or home phone a day before your appointment. You can also schedule online at any time. Once your account is established, you simply visit www.therapyappointment.com. If you want to utilize this service, please complete the following:

Requested Login Name:_____ Requested Password: _____

Your Email address:_____@_____

Your Cell Phone Number:_____-_____-_____. Your service carrier:_____

Where would you like to receive appointment reminders? (check one)

_____ via a text message (normal text message rates will apply)

_____ via an email message

_____via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (missed appointment fees will still apply.

Appointment information is considered to be "protected health information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date