Below is the information that I would like included in the intake form. I am also attaching a copy of my Intake form as it is for layout issues, though I know it will change since we are creating a new form.

# Section Header

## Subsection Header

Required Information\*

* Drop down box/radio button

# Client Information

## Name and Contact Information

First Name\*

Last Name\*

Preferred Name

Phone\*

Email Address\*

Address\*

* Street
* City
* State
* Zip

## Emergency Contact

Name\*

Phone Number\*

Relationship\*

## Place of Service\*

* Fort Worth, TX
* Hattiesburg, MS
* Telehealth

## Demographic Information

**Birthday\***

**Legal Gender\***

* Male
* Female
* Transgendered M-F
* Transgendered F-M
* Non-Binary
* Other

**Gender Identity**

* Agender
* Female
* Gender Fluid
* Gender Non-conforming
* Genderqueer
* Intersex
* Male
* Non-Binary
* Trans Female
* Trans Male
* Two Spirit
* Questioning
* Choose Not to Disclose
* Other

**Pronouns**

**Sexual Orientation**

* Asexual
* Bisexual
* Gay
* Heterosexual
* Lesbian
* Pansexual
* Polysexual
* Queer
* Questioning
* Choose Not to Disclose
* Other

**Race\***

* Black/African-American
* Asian
* Hispanic/Latino
* Multiracial
* American Indian/Alaska Native
* Hawaiian Native/Pacific Islander
* White/Caucasian
* Other

**Marital Status\***

* Married
* Single
* Widowed
* Divorced
* Separated
* Common Law
* Living Together
* Partners
* Engaged

# Insurance Information

Do you have medical insurance?\*

* Yes
* No

Responsible Party

Birthday

Relationship to Client

Address (if different)

**Insurance Provider\***

* Aetna
* Blue Cross Blue Shield
* Cigna
* Tricare
* United Healthcare/UMR
* Other

Insured Name

Policy Number\*

Group Number

Copay\*

Client’s’ Relationship to Insured\*

* Self
* Spouse
* Child
* Other (required to list)

Do you have a secondary insurance?

Upload a copy of insurance card\*

I understand that by submitting my insurance information, I am giving Accepted Therapy Services permission to file on my insurance. This includes releasing information including:

\_\_\_\_ Assessment

\_\_\_\_ Diagnosis

\_\_\_\_ Participation in treatment

\_\_\_\_ Progress in treatment

\_\_\_\_ Demographic information

I further understand that no progress notes will be submitted unless additional authorization is received by Accepted Therapy Services in writing.

**Signature Box**

# Presenting Problem

What is your major complaint or issue that you would like to address?

Have you previously suffered from this issue?

Have you ever been diagnosed with a mental illness (Generalized Anxiety Disorder, Major Depressive Disorder, ADHD, PTSD, personality disorder, etc.)? If so, when?

Current Symptoms:

|  |  |  |
| --- | --- | --- |
| ( ) Anxiety | ( ) Appetite Issues | ( ) Avoidance |
| ( ) Crying Spells | ( ) Depression | ( ) Excessive Energy |
| ( ) Fatigue | ( ) Grief/Loss | ( ) Guilt/Shame |
| ( ) Hallucinations | ( ) Impulsivity | ( ) Irritability |
| ( ) Libido Changes | ( ) Lost of interest | ( ) Panic Attacks |
| ( ) Racing Thoughts | ( ) Risky Activity | ( ) Sleep Changes |
| ( ) Suspiciousness | ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you ever received therapy in the past? If so, please provide treatment received and dates of treatment.

# Medical History

Primary Care Provider:

Phone Number:

Are you currently taking any medications?

* Yes
* No

Add another medication

What medications have you tried previously that did not work for you?

Do you have any medical conditions?

# Mental Health History

## Suicidal Ideations

Do you have any of the following:

Current suicidal ideations?

* Yes
* No

Current suicide plan?

* Yes
* No

Current self-harming behaviors?

* Yes
* No

History of suicidal ideations?

* Yes
* No

Previous suicide attempts?

* Yes
* No

History of self-harming?

* Yes
* No

## Substance Use

### Nicotine/Caffeine

Do you use nicotine (smoking, vaping, chewing tobacco, etc.)?

How many caffeinated beverages do you drink per day?

### Alcohol

How much alcohol do you typically consume?

* None
* 1 to 2 times per week
* 3 to 4 times per week
* More than 5 times per week

How many drinks do you have on a typical day when you are drinking?

* 1 or 2
* 3 or 4
* More than 5 drinks

Has anyone ever told you that you drink too much?

### Illicit Drugs

Have you ever tried any of the following?

* Cocaine
* Ecstasy
* Hallucinogens (LSD)
* Heroin
* Marijuana
* Methadone/Suboxone
* Methamphetamines
* Opioids (pain killers)
* Stimulants (pills)
* Tranquilizers

Have you ever misused or abused prescription drugs?

# Addition Information

## Work

Occupation

Employer

Do you enjoy what you do?

## Marriage

Are you married?

Have you ever been divorced?

Do you have any prior marriages?

How is your relationship with your partner?

* Excellent
* Good
* Fair
* Poor

## Children

Do you have any children (including step-children)?

Add another child

## Religion/Spirituality

What is your religion?

* Agnostic
* Atheist
* Buddhist
* Catholic
* Christian
* Hindu
* Jewish
* Latter-Day Saints
* Muslim
* Orthodox
* Protestant
* None
* Other

Is spirituality important to you?

# Family History

Were you adopted?

Relationship of Parents:

* Married
* Divorced
* Separated
* Step Parents
* Widowed

Is your mother living?

* Yes
* No

How is/was your relationship with your mother?

* Excellent
* Good
* Fair
* Poor

Is your father living?

* Yes
* No

How is/was your relationship with your father?

* Excellent
* Good
* Fair
* Poor

How many siblings do you have?

* 0
* 1
* 2
* 3
* 4
* Other

What is your birth order?

## Medical Conditions

Does anyone in your family have any medical conditions? If so, specify medical condition and member of family affected.

## Mental Health

Do you have any family history of mental illness? If so, specify diagnosis and member of family affected.

Is there anything else that you want your therapist to know?