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DEMOGRAPHIC INFORMATION**DATE**

Client Name:	Home Phone:
Address:	Cell Phone:
	Work Phone:
DOB & Age:	Email Address:
SSN:	Contact Person & Relationship to Client:
Referral Source:	Emergency Contact Phone Number:

INSURANCE & BENEFIT INFORMATION (if applicable)

Insurance Company:	Provider Services Phone #:
Insurance ID #:	Group #:
Subscriber Name:	Client Relationship to Subscriber:
Subscriber DOB:	Subscriber Employer:
Subscriber SSN:	Policy Effective Date:
Co-pay/Co-Insurance:	Deductible (Amount met?):
# Visits Allowed:	Preauthorization Required?

CANCELLATION POLICY & OUTSTANDING BALANCES

A 24-hour advance notice is required for cancellation of your scheduled appointment. A missed appointment fee will be charged at **FULL OUT-OF-POCKET FEE** to the credit card on file.
After 60 days, any unpaid balance will be charged to the credit card on file. You will be refunded upon the receipt of insurance payments for outstanding dates of service.

CERTIFICATION AND AUTHORIZATION (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Healthy Minds Therapy, PLLC on my behalf. Therefore my signature will be on file to file with my insurance company.

Signature of Patient: _____
Date: _____

ADULT INTAKE FORM

Client Name:	Date of Birth:
Marital Status:	Age:
Race/Ethnicity:	Gender:

Current Symptoms (Check All That Apply)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> I have no problems or concerns <input type="radio"/> Aggression, violence <input type="radio"/> Anger <input type="radio"/> Anxiety <input type="radio"/> Difficulty concentrating <input type="radio"/> Career concerns <input type="radio"/> Parenting concerns (your own child) <input type="radio"/> Custody of Children <input type="radio"/> Delusions (false ideas/hallucinations) <input type="radio"/> Drug or Alcohol Dependence <input type="radio"/> Depression <input type="radio"/> Divorce/Separation <input type="radio"/> Eating problems <input type="radio"/> Fatigue/low energy <input type="radio"/> Fears, phobias <input type="radio"/> Financial problems | <ul style="list-style-type: none"> <input type="radio"/> Grief <input type="radio"/> Health, medical concerns <input type="radio"/> Interpersonal conflicts <input type="radio"/> Irritability <input type="radio"/> Legal matter problems <input type="radio"/> Loneliness <input type="radio"/> Martial/relationship problems <input type="radio"/> Memory problems <input type="radio"/> Mood swings <input type="radio"/> Nervousness/tension <input type="radio"/> Obsessions & compulsions <input type="radio"/> Chronic pain <input type="radio"/> Panic or anxiety attacks <input type="radio"/> Perfectionism <input type="radio"/> School problems | <ul style="list-style-type: none"> <input type="radio"/> Self-esteem <input type="radio"/> Sexual problems <input type="radio"/> Shyness, oversensitive to criticism <input type="radio"/> Sleep problems <input type="radio"/> Smoking and tobacco use <input type="radio"/> Spiritual, moral, religious, ethical issues <input type="radio"/> Stress <input type="radio"/> Suicidal thoughts <input type="radio"/> Thought disorganization and confusion <input type="radio"/> Withdrawal or isolation <input type="radio"/> Work problems <input type="radio"/> Other _____ |
|--|---|--|

How long have these difficulties been present?

What are your goals for treatment?

Mental Health History

Have you received mental health treatment in the past?				
Date(s)	Therapist/Facility	Reason for seeking treatment	Length of treatment	Was treatment helpful?

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	
Diagnosis (if known):	

	YES	NO	If yes, please describe:
Have you ever been hospitalized for mental health reasons:			
Have you ever had thoughts about death or wanting to die? Have you ever threatened to hurt yourself?			
History of suicidal gestures and/or attempts:			
Any legal history:			

Alcohol/Substance Use

Please describe your current use of drug, alcohol, and/or tobacco.			
	YES	NO	If yes, please describe:
Has using drugs or alcohol ever caused problems for you?			
Have you ever been treated for drug or alcohol abuse?			

Medical History

Please list all medical concerns here:

Please list all medical concerns here:

List any **CURRENT** or **PREVIOUSLY** prescribed **PSYCHIATRIC** medications below

[illegible]

Family and Social History

Family Members (include spouse, children, parents, siblings)	Sex	Age	Relationship	Living at Home?	
				Yes	No

Is there anyone else living at home?

	YES	NO	If yes, please describe:
Is there a history of psychiatric/psychological disorders in family? (For example, depression, anxiety, learning disorders, bipolar disorder, schizophrenia, etc.)			
Is there a history of drug or alcohol abuse in the family?			
Is there a history of suicide in the family?			

What was your birth order: _____ out of _____

Education/Employment History

Education		Spouses' Education (if applicable)	
Highest Degree Completed:		Highest Degree Completed:	
Major		Major	

History of Learning Disorder/Difficulties. If yes, please describe:

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important for me to know?

My signature below indicates that I have voluntarily and accurately completed the form. A photocopy of this agreement will be considered as valid as an original.

Client Name

Client Signature

Date