4528 Plank Road Suite A1 #340
Fredericksburg, VA 22407

Phone: (540)845-6940 Fax: (484)842-6053
website: http://www.healthyminds-therapy.com

2200 Opitz Blvd
Woodbridge, VA 22191

950 N Washington St Suite 322 Alexandria VA 22314

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 (varies by location) 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)

- o I have no problems or concerns
- o Aggression, violence
- o Anger
- o Anxiety
- o Difficulty concentrating
- o Career concerns
- o Parenting concerns (your own child)
- o Custody of Children
- o Delusions (false ideas/hallucinations)
- o Drug or Alcohol Dependence
- o Depression
- o Divorce/Separation
- o Eating problems
- o Fatigue/low energy
- o Fears, phobias
- o Financial problems
- o Grief
- o Health, medical concerns
- o Interpersonal conflicts
- o Irritability
- o Legal matter problems
- o Loneliness
- o Martial/relationship problems
- o Memory problems
- o Mood swings
- o Nervousness/tension
- o Obsessions & compulsions
- o Chronic pain
- o Panic or anxiety attacks
- o Perfectionism
- o School problems
- o Self-esteem
- o Sexual problems
- o Shyness, oversensitive to criticism
- o Sleep problems
- o Smoking and tobacco use
- o Spiritual, moral, religious, ethical issues
- o Stress
- o Suicidal thoughts
- o Thought disorganization and confusion
- o Withdrawal or isolation
- o Work problems
- o 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:

List any **CURRENT or PREVIOUSLY** prescribed **PSYCHIATRIC** medications below				
Date(s) Prescribed	Medication	Dosage & Frequency	Reason for prescription	Is/was the medication helpful?

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*