Quince Orchard Psychotherapy

Compassionate, Client-centered Care

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Initial Adult Intake Form

A. Identifications

Name: _____ Birth date: _____
Preferred Name (If different than above):_____

Preferred pronoun:_____ Preferred gender:_____ Age: _____
Today's date: _____
Primary phone #: _____
Address:_____
_____
Highest school grade completed:_____Occupation:_____
Email address:_____

Marital Status: _____

Religious denomination/affiliation (specify, if applicable):
_____
Involvement: ❑ None ❑ Some/irregular ❑ Active

Ethnicity/national origin: _____
Other important identifiers: _____

B. Referral: How did you find out about the practice?
_____

C. Medical care: From whom or where do you receive medical care?
Clinic/doctor's name: _____ Phone: _____
Address:_____
May I contact your medical doctor so that he or she can be fully informed and we can coordinate treatment?
❑ Yes ❑ No

Health Insurance Information (We will need to make a copy of your card(s))
Name of Primary insurance company: _____
Primary Subscriber's Name, Date of Birth, and
Address:_____
Member ID number:_____ Group number (if applicable):_____

Name of Secondary insurance company: _____
Primary Subscriber's Name, Date of Birth, and
Address:_____
_ Member ID number:_____ Group number (if
applicable):_____**D. Emergency information**
If some kind of emergency arises and I cannot reach you directly, whom should I call?
Name:_____ Phone: _____ Relationship: _____
Address:
_____

E. Chief concern
Please describe the main difficulty that has brought you to see me. How long has it persisted?
_____

_____

_____

_____

_____

F. Prior Treatment
1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling servicesbefore?

❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

2. What medication(s) are you currently taking? If applicable, please indicate the medication, the dosage, and the prescribing
physician:_____

What medication(s) have you taken in the past?:_____ 3.
Have you ever received psychological testing? If so, whom may I contact for a copy of the report?_____
_____

G. Health

List all illnesses, hospitalizations, medications, allergies, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(list more on the back of this page if necessary)

Is there a family history of any medical or mental health problems? Please describe:_____
_____
_____

Have you ever been exposed to traumatic events (the loss of a loved one, a natural disaster, etc.) or been subject to abuse or neglect (physical, verbal, sexual, or emotional)? Please describe:_____
_____

H. Unique attributes

What are your hobbies? What do you do for fun?
_____
_____
_____

What do you see as being your strengths and weaknesses?_____
_____
_____

I. Relationships

Please briefly characterize how you get along with:
Family:_____
_____
_____

Significant Other: _____
_____
_____

Friends: _____
_____
_____

Other important relationships: _____
_____

J**. Risk taking**

Do you have a history of behaviors such as lying, stealing, excessively using drugs or alcohol, fighting, etc.?

_____
_____

If so, have you had any serious consequences (problems at school or work, legal involvement, etc.)? Please describe:_____
_____
_____

K. Other

Are there any stressful events occurring in your life right now that could be affecting you?_____
_____

Is there anything else I should know about that does not appear on this form and that might be important?

_____
_____
_____
_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

ADULT INFORMED CONSENT

I will keep confidential from outside parties anything you say to me with the following exceptions:

-I determine you are a danger to yourself or others (but I will make every effort to include you in this determination);
-Child, elder, or dependent person abuse reporting as mandated by law;
-I am ordered by a court to disclose information (this includes the possibility in child custody situations or litigation);
-If legitimate fee collection efforts become necessary;
-HIV status may need to be disclosed to an unknowing spouse or partner as mandated by law; -You direct me to tell someone else by signing a release of information form. This includes releases you sign with an insurance company which are activated once you apply for reimbursement. This also includes a mental disorder diagnosis that I place on a bill submitted to insurance for reimbursement.

In the event I feel I need to consult with another professional in order to provide for your needs, I will do so, but only in a professional manner. Your identity will be kept anonymous. I will use the same guidelines as above to maintain confidentiality. Tell me if this is a concern.

I certify that I have read and accept the included brochure about my psychologist's policies and procedures. I understand that it is my responsibility to ask any questions that I may have of my clinician before signing. I understand that we will now begin with an assessment of my needs and that neither the therapist nor I are under any obligation to continue with treatment from that point. I further understand that mental health is not an exact science and that no guarantee can be made as to the result or success of my treatment. I understand that treatment often involves making significant changes and that every change potentially has both positive and negative effects. I understand the potential benefits and risks involved in seeking mental health treatment and am willing to proceed at this time. I understand that I can discuss any questions or concerns that I have with my clinician.

Client #1 Print: _____ Date: _____

Client #1 Signature:_____

Client #2 Print: _____ Date: _____

Client #2 Signature:_____

Client #3 Print: _____ Date: _____

Client #3 Signature:_____

Therapist: _____ Date: _____