Confidential Client Intake Information

The information you provide will be kept confidential and will be helpful in planning counseling services for you and/or your child. Please answer each item to your best ability (please print clearly).

Name _____ Preferred name _____

Address _____

City, state, zip code _____

Phone number _____ Permission to contact you here? ☐ Yes ☐ No

Email _____Permission to contact you here? ☐ Yes ☐ No

Age _____ Birthdate _____ Gender _____

Racial/ethnic identity ☐ African-American/Black ☐ Asian or Pacific Islander ☐ Caucasian/White ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Other _____

Referral Source ☐ Psychology Today ☐ Google ☐ EAP ☐ Family ☐ Friend ☐ Facebook ☐ Physician ☐ Former Client ☐ Insurance ☐ Therapist ☐ Other _____

Emergency contact name _____ Relationship _____

Phone _____ Permission to contact in case of emergency? ☐ Yes ☐ No

Current occupation _____ Employer _____

Current relationship status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabitating

Spouse/partner's name _____ Age _____ Years in relationship _____

Names and ages of your children _____

_____

Family physician name and last visit _____

Psychiatrist name and last visit _____

Please list any significant current or previous medical problems _____

_____

_____

Please list any prescription medications (dose, frequency) you currently take_____

_____

_____

Have you had previous counseling? ☐ Yes ☐ No

If yes, please give the name of the therapist(s), the year(s) you saw them (e.g., 2008 - 2009), and the nature of the difficulty at the time _____

_____

Have you ever been hospitalized for a psychiatric difficulty? ☐ Yes ☐ No

If yes, please give the year(s) and the nature of the difficulty at the time _____

_____

_____

Please list any previous or current diagnosis given by a professional _____

_____

Please check primary reason(s) for seeking counseling:

ADULTS

☐ Anxiety ☐ Depression ☐ Grief/loss ☐ Nervousness ☐ Loneliness ☐ Loss of hope

☐ Conflicts at work ☐ Loss of job ☐ Compulsive behavior ☐ Eating/body image

☐ Abuse or assault ☐ Self-esteem ☐ Stress ☐ Alcohol/drug use ☐ Cutting/self-harm

☐ Suicidal thoughts ☐ Anger ☐ Chronic pain ☐ Appetite concerns ☐ Sleep concerns

☐ Legal issues ☐ Marital conflicts ☐ Family conflicts ☐ Relationship conflicts ☐ Gender identity

☐ Sexual/intimacy concerns ☐ Divorce adjustment ☐ Major life transition/change

☐ Other _____

_____

CHILDREN/ADOLESCENTS

☐ Anxiety ☐ Depression ☐ Grief/loss ☐ Poor grades ☐ Truancy ☐ Running away ☐ Hyperactive

☐ Fighting with peers ☐ Fighting with family ☐ Bed wetting ☐ Isolation ☐ Oppositional

☐ Parent – child conflict ☐ Teacher – child conflict ☐ Alcohol/drug use ☐ Sexual promiscuity

☐ Bullying ☐ Abuse ☐ Anger/aggression ☐ Crying ☐ Biting, kicking, spitting ☐ Yelling/cursing

☐ Self-harm/cutting ☐ Adjusting to divorce/remarriage ☐ Blended families ☐ Cruelty to animals

☐ Poor attention/focus ☐ Suicidal thoughts ☐ Suicide attempt(s) ☐ Other _____

_____

Please answer the next three questions regarding your presenting problems:

1. How severe do you consider your presenting problem/concern(s)?

☐ Not severe ☐ Somewhat severe ☐ Moderately severe ☐ Very severe

2. How motivated are you to resolve your presenting problem/concern(s)?

☐ Not motivated ☐ Somewhat motivated ☐ Moderately motivated ☐ Very motivated

3. How optimistic are you that your presenting problem/concern(s) can be resolved?

☐ Not optimistic ☐ Somewhat optimistic ☐ Moderately optimistic ☐ Very optimistic

What do you hope to achieve from counseling?

_____

_____

_____

_____

What other information would you like to share?

_____

_____

_____

_____

Payment Information

Check one:

☐ PRIVATE PAYMENT - I do not intend to use mental health insurance to pay for my services at Grief Recovery Center. I understand that I am responsible for full payment for services at each visit.

☐ EAP (Employee Assistance Program)

☐ OUT-OF-NETWORK INSURANCE – I intend to use out-of-network insurance benefits to cover my services at Grief Recovery Center. I understand that I am responsible for full payment for services at each visit and will use clinic receipt to seek reimbursement from my insurance company. I recognize that insurance companies vary in the percentages of reimbursement provided. I recognize that it is my responsibility to secure this preauthorization.

☐ IN-NETWORK INSURANCE – I intend to use my primary in-network insurance coverage benefits to cover my services at Grief Recovery Center. I understand that it is my responsibility for the co-payment and/or co-insurance amount for my visit at the time of service. I authorize Grief Recovery Center to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company, if any, be made to Grief Recovery Center, unless otherwise indicated on the claim. I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier. In making this assignment, I understand that I am financially responsible for any charges not paid under this insurance policy. I further understand that Grief Recovery Center will not file for secondary insurance on my behalf.

The following information applies to the insurance **policy holder**:

Policy Holder's Name (as it appears on card) _____

DOB _____

Address _____

Insurance company name _____

Policy number _____

Group and/or plan number _____

Policy holder's relationship to client ☐ Self ☐ Spouse ☐ Child ☐ Other _____

_____

Client Signature Date

_____

Family Member/Guardian Signature (if applicable) Date