Patient Intake Information

1400 Preston Road, Suite 400, Plano, Texas 75093
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972-665-9915 Fax

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972-665-9835 Ofc. 972-802-5767 Ofc. Cell
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Date:__________________ **Patient #**______________ **Therapist:**___________________
For Office Use Only

Name:________________________________Social Security #___________________ Hm Phone: _______________

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail address:____ Cell Phone:_________________________

Age:_______ Birth Date:___________ Race(optional):________ Marital: M S W D

Your Occupation:__________________________ Employer:____

Employer's Address:____ Office Phone:_________________________

Spouse:________________________ Occupation:________________ Employer:_____________________________

Employer's Address:____ Wk Phone:_________________________

How many children?____________ Names and Ages of Children:____

____

Name of Nearest Relative:__________________________________ Phone:________________________________

How were you referred to our office?______________________ Do you want Christian Counseling YES NO

Family Medical Doctor (name, address & phone):____

May we have your permission to update your medical doctor regarding your care at this office? YES NO

May we contact you by e-mail if necessary? YES___ NO___ Email Address:_____________________________

HISTORY OF PRESENT CONDITIONS:

Purpose of this appointment:____

____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

____

PAST HISTORY - Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety __Eating Disorder
__ Depression __ Post Traumatic Stress Disorder
__ Anger __ Adoption Issues
__ Abandonment __ Other. List: _______________________________________
__ Alcoholism __ Drug Addiction __ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth, miscarriages and terminations (include dates and explain what impact it had on you if any)

____

____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: ____

What medications are you taking? (List name and dosage) ____

____

SOCIAL HISTORY:

Do you drink alcoholic beverages?______ If so, how much per week?____________________________________
Do you use any tobacco products?______Do you smoke?____ If so, packs per day: _________________________
Do you take vitamin supplements?______ If so, please list:____
Do you consume caffeine?_____ If so, how much per day:____
Do you exercise?_____ If yes, what is the frequency and type of exercise?___________________________________
Do you sleep well at night? _____ If no, why not? ____
What are your hobbies?____
What percentage of time during the day (at home or at your job away from home) do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:

Parents:
Father: living ___ deceased ____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____

Mother: living ___ deceased ____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _________
____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Drug Addiction
__ Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Alcoholism
__ HIV Positive
__ Other____________________________________

Other Information:
Have you ever been arrested? ____

Are you willing to complete and sign a release of information so your counselor may obtain social, psychiatric, or Medical information? Yes ___ No ___ please explain: ________________________________

Have you recently suffered loss from serious personal, social, business, or other reversals?
Yes__________ No _________
Please explain: ____
____

Have you ever been the victim of a crime? Yes _______ No _______
If so, have you filed with Texas Crime Victims Compensation? Yes _______ No _______
Please identify any previous marriages: ____

Personality Information:
Have you ever had counseling before? Yes _______ No _______
Describe the outcome: ____
Please list dates and names of counselor:____
Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment?____

***Please circle any of the following words which best describe you now*:** active, ambitious, self-confident, persistent, nervous, hardworking, impatient, impulsive, moody, often-blue, excitable, imaginative, calm, serious, easy-going, shy, good-natured, introvert, extrovert, likable, leader, quiet, stubborn, submissive, lonely, self-conscious, sad, fatigued, anxious, sensitive, other___________________________________

****INSURANCE INFORMATION - Please check any insurance coverage that you will be using:**

___ Major Medical ___ Medicaid ___ Medicare ___ HSA or FSA ____ Spending Account ____ Other____

What is your office visit co-pay? $_______ How do you wish to pay your co-pay? CC___ Check____ Cash____

If you will pay your co-pay by credit or debit card provide the following: CC Name:______________________________

CC#___________________________ Exp Date________ 3Digit pin on back of card______

Whose Name is the Insurance In? ___________________________What is that person's Date of Birth? __________

Name/Address of Primary Ins. Co: ________________________________Ph:______________ ID#_______________

Group#__________ Name/Address of Secondary Ins. Co:________________________________ Ph:_____________

ID#_______________ Group#__________ Whose Name is the 2nd Insurance In? ___________________________

What is that person's Date of Birth? __________

AUTHORIZATION AND RELEASE: I authorize my co-pay to be charged to the credit card shown above. I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with my personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable. Signature:____

1. What is your major concern? ____
____
____
____

2. If this is a recurrence, when was the first time you noticed this problem?_________________________
How did it originally occur?____
____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
If yes, when and how? ____
____

3. How frequent is the condition? Constant _____ Intermittent ____
What causes the problem to come on/get worse?
____
____
____

4. Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________
____

5. Is there anything you can do to relieve your major problem? Yes ___ No ___. If yes, describe:
____
If no, what have you tried to do that has not helped? _______________________________________
____

6. What makes the problem worse? ____
____

Please complete the information below and sign the form.

NO SYMPTOMS/STRESS ____ EXTREME SYMPTOMS/STRESS

Please place an "X" on the line above to indicate level of problem.

The patient/client understands and agrees to allow this healthcare office to use his/her protected health information for the purposes of treatment, payment, healthcare operations, and coordination of care. Your protected health information will be used solely for treatment, payment and healthcare operations.

Patient's or Guardian's Signature:____ Date:________________

Therapist's Signature ____ Date _____________