

ADULT INTAKE INFORMATION – page 1
(To be completed by client)

Client's Name: _____ Today's Date _____

Partner's Name (if being seen as a couple): _____

Address: _____ City, State, Zip: _____

Home phone: _____ Work phone: _____ Partner's phone: _____

Social Security (ID) Number: Self: _____ Partner (optional): _____

May we leave messages for you at home? Yes No May we leave messages for you at work? Yes No

Gender: M F Age: _____ Birth Date: _____ Marital Status: _____

Others Living in Home (name, birth date, relationship to client): _____

Education: Self: _____ Partner: _____

Occupation: Self: _____ Partner: _____

Client's Employer: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

INSURANCE INFORMATION

Name of Insured: _____ Insured Date of Birth: _____

Address of Insured: _____ City, State, Zip: _____

Relationship of Client to Insured: _____ Employer of Insured: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____ City, State, Zip: _____

Insurance Identification Number: _____ Group Number: _____

Secondary insurance: _____ Phone: _____

Name of Secondary Insured: _____ Insured Date of Birth: _____

Secondary Company Address: _____ City, State, Zip: _____

Secondary Identification Number: _____ Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services

_____ Date: _____

FOR OFFICE USE ONLY
DIAGNOSIS:

ADULT INTAKE INFORMATION – page 2

(To be completed by client)

MEDICAL HISTORY

How do you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Had any major injuries or accidents? (please circle)

Yes No

Major illnesses? (please circle)

Yes No

Are you currently experiencing any chronic pain? (please circle)

Yes No

How do you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you exercise? _____

Name of your Primary Care Physician: _____

Phone: _____ Address: _____

Date of your most recent physical exam: _____

List all medications you are currently taking & the dosage of each, if known:

Name of Psychiatrist or Psychiatric Nurse Practitioner: _____

Mental Health History:

Are you currently experiencing any of the following? (please circle)

Overwhelming sadness, grief or depression Yes No

Anxiety, panic attacks or have any phobias? Yes No

Eating problems? Yes No

Sexual problems? Yes No

Hyperactivity or uncontrollable energy? Yes No

Difficulty paying attention or concentrating? Yes No

Has the client or anyone in your family ever received counseling? ___Yes ___No

Has anyone in the family ever received medication or been hospitalized for mental health reasons? ___ Yes ___ No

Has anyone in the family threatened or attempted suicide? ___ Yes ___ No

ADULT INTAKE INFORMATION – page 3

(To be completed by client)

Has your or a family member's drug or alcohol use caused problems in the family?

_____ Yes _____ No

If yes please explain_____

Primary substance

Age of first use

Number of days since last use

Frequency of use or degree of impairment

Additional Information:

Do you enjoy your work? Is there anything stressful about your current work?

What is your ethnic/cultural background and spiritual or religious background?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy? (the reason you are seeking services):

Paula Levinrad provides services to all clients who are eligible regardless of race, color, religion, national origin, sex, age, marital status, disability, or other factors prohibitive by law or regulation.

I authorize billing to my insurance company and payment of medical benefits directly to Paula Levinrad. I authorize Paula Levinrad to provide information to my insurance company that is necessary to complete this billing process.

I agree to provide at least 24 hours notice of cancellation of an appointment

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature of Client or Guardian_____ Date:_____

