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: _________

Cell : __________________________________

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

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:________________________