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Date: _____
Primary Patient: _____ Marital Status: _____
Last First M.I.
Date of Birth: _____ age _____ Sex: _____ SS#: _____ DL# _____
If a minor, who will be responsible for appointments and charges? _____
Home Address: _____
Street City State Zip
Home Phone _____ Work Phone _____
Occupation: _____ Employer: _____
Spouse's Name: _____ Date of Birth: _____ age _____ SS#: _____
Spouse's Occupation: _____ Spouse's Employer: _____
Spouse's Home Phone _____ Work Phone _____
Name of Emergency Contact: _____ phone: _____

Are you insured? _____ If yes, Insurance Company: _____ phone: _____
Insured's Employer: _____ Policy #: _____ SS#: _____

Is there a second insured in the family? _____ Whom? _____

Name of other Family members	Age	Sex	Date of Birth	Relation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

By whom were you referred? _____ Please briefly state your reason for coming: _____

Current medications / medical problems / Physician's Name: _____

Past or current psychological / psychiatric / counseling services: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned, assign all medical benefits, including major medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my provider to release any information necessary to secure the payment of benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

SIGNATURE _____ DATE _____

Please answer the following questions as completely as you can. If you do not understand or do not know how to answer a question, leave it blank and continue with the questionnaire.

INTAKE INTERVIEW

NAME: _____

DATE: _____

Presenting Problem Information:

Why are you here? _____

Have you been treated for this problem before? Yes _____ No _____

When? _____ Where? _____

By Whom? _____

Have you been hospitalized for psychiatric or substance abuse problems within the past year?

Yes _____ No _____

If yes, when? _____ Where? _____

MARITAL HISTORY: ___ M ___ S ___ D ___ W How Long _____

Is this a first marriage? _____ Wife _____ Husband _____

WORK HISTORY:

Current Employment: _____ How Long _____

(if less than 5 yrs fill out previous emps.)

Current work related problems? _____

Previous Employers: _____ How Long _____

_____ How Long _____

_____ How Long _____

Problems with previous employers: _____

Name: _____

Presenting Symptoms:

A: Suicidal Thoughts: _____ Yes _____ No
Plan: _____ Yes _____ No

(1) Describe frequency, previous attempts:

(2) What prevented follow through:

B. Assaultive Behaviors: _____ Yes _____ No

Describe incidents: _____

C: Family Problems: _____ Yes _____ No

Describe:

D: Substance Abuse: _____ Yes _____ No
TYPE AMOUNT FREQUENCY LAST USE

Problem areas due to S/A:

a: Have you noticed any problems yourself? _____

B: Has anyone told you of any problems they see you are having? _____

Name: _____

SCHOOL HISTORY:

High School: _____ Yes _____ No _____ GED

College Attended: _____

Degree Obtained: _____

HEALTH HISTORY:(major illnesses, operations, etc.)

OTHER SYMPTOMS: Have you noticed a change of behavior in any of the following?

Appetite: _____

Interests: _____

Energy: _____

Concentration: _____

Sleep: _____

Suicide: _____

Drugs & Alcohol: _____

Please check Yes if you have experienced any of the following. Check No if you have never experienced any of these and check Unknown if you do not know or do not understand the question.

	Yes	No	Unknown
Change in appetite	_____	_____	_____
Weight gain/loss	_____	_____	_____
Unable to sleep or sleeping a lot	_____	_____	_____
Bed wetting	_____	_____	_____
Firesetting	_____	_____	_____
Runaway behavior	_____	_____	_____
Mood swings	_____	_____	_____
Lying	_____	_____	_____
Lack of concentration	_____	_____	_____
Impulsivity	_____	_____	_____
Hyperactivity	_____	_____	_____
Hallucinations/ delusions/illusions	_____	_____	_____
Peer group change	_____	_____	_____
Significant losses	_____	_____	_____
Suicidal thoughts/ suicidal attempts	_____	_____	_____
Alcoholism	_____	_____	_____
Chemical dependency	_____	_____	_____
Eating disorders	_____	_____	_____
Sexual addiction	_____	_____	_____
Physical abuse	_____	_____	_____
Emotional abuse	_____	_____	_____
Incest	_____	_____	_____
Work addiction	_____	_____	_____
Religious Addiction	_____	_____	_____
Gambling/spending addiction	_____	_____	_____
Mental Illness	_____	_____	_____
Chronic Illness	_____	_____	_____
Suicide	_____	_____	_____
Codependency	_____	_____	_____
Sexual problems	_____	_____	_____
Financial problems	_____	_____	_____
Out of control behavior	_____	_____	_____
Self-mutilization	_____	_____	_____
Unpredictable behavior	_____	_____	_____

RELEASE OF INFORMATION

I, _____ SSN: _____
(Client/Parent/Guardian)

hereby authorize _____
(Provider of services, title)

To release information pertinent to my condition. The following may be released:

- Assessment of condition / diagnosis
- Tests pertaining to treatment conditions
- History of previous treatment
- Goals of present treatment
- Date(s) of service
- Description and results of treatment
- Other _____

This information may be released for the purpose of:

- Procuring payment for services from a third party (insurance, EAP, etc.)
- Procuring a work excuse or excuse of absence from work or school
- Continuity of care to a Primary Care Physician or other provider
- Other _____

This information may be released to: _____

I understand that my record may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code 2.1 et seq. (1087), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

- At discharge date, or at date final payment is secured from third party
- In thirty days from the date this document is signed
- Other _____
(specification of the date, event, or condition upon which this consent expires)

Signature

Date

Printed Name

Client's Name if Parent/Guardian is signing

Witness Signature

Printed Name of Witness

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____, _____, _____, for the purpose of coordinating
(Patient Name - Print) (Patient d.o.b.) (Patient Social Security #)

care, authorize _____, to release information related to my evaluation and treatment to:
(Provider Name - Print)

PCP Name: _____ PCP Phone: _____

PCP Address: _____
(Street) (City) (State) (Zip)

Information For PCP:

The patient was seen by me on (date): _____ for (Diagnosis): _____

Treatment Plan : _____

For Psychiatrist's Only:

The following medication(s) was/will be started: (list medications and dosage) _____

___ Medication was not indicated ___ Patient refused medication ___ Psychotherapy suggested before trying med.

___ I recommend the following medical intervention by PCP before initiating medications:

Medical work-up for: _____

Lab tests for: ___ CBC ___ Thyroid Studies ___ Chem Panel ___ EKG

Other: _____

Please call me at () _____, to discuss this case further or if you need any other information.

(Provider signature) (Provider Printed Name) (Licensure)

CONSENT

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent.

Patient please check one:

- () To release any applicable mental health/substance abuse information to my primary care physician.
- () To release only medication information to my primary care physician.
- () I do not give my consent to releasing any information to my primary care physician.

Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

Witness (Date)

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose

PROVIDER: Please Send a Copy of this Signed Form to the Primary Care Physician and Keep the Original in the Patient's Treatment Record