Intake Form and Signature Page

Date: ______________________________

Patient Information:

Print Name (Last, Middle First): ______________________________

Street Address: ______________________ City: __________________ State: ______

Mobil phone: ______________________ Alternate phone: ______________________

Email (please print) ______________________________

Date of Birth: ______________ Age: ______ Gender Identity: ______________________

Goals of Treatment:

What compelled you to seek therapy at this time? ______________________________

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How did you hear about Sue Speake, LMFT? Website: □ Twitter: □ A Friend: □

Doctor or Therapist Referral: □ Name: ______________________________

Emergency Contact Information: (Who you want me to contact in case of an emergency)

Name: ______________________________ Relationship: ______________________

Phone number: ______________________

Payment Information: Sue Speake, LMFT does not accept insurance and is not on any insurance panels. Please indicate how you intend to pay for treatment: Cash: □ Check: □ Credit Card: □

Mental Health Treatment History:

Have you ever been in counseling or therapy in the past? Yes: □ No: □

Have you ever been hospitalized because of a mental health disorder? Yes: □ No: □

How long was your hospitalization? ______________________________

Why were you hospitalized? ______________________________

Are you currently taking any psychiatric medications? Yes: □ No: □

If so, please list the medication you have been prescribed, the dosage, and any side effects in the space below.

Medication (psychiatric only)	Dosage	Side Effects

Medical Treatment Information:
Are you currently receiving treatment for a serious or chronic physical-medical condition? Yes: □ No: □
If you currently have a serious medical condition, please provide the diagnosis:

____

Your signature indicates your agreement for services and to be responsible for the fees. Please ask your therapist to address any questions or concerns that you have before you sign.

Patient Signature:_____________________________________ Date: ________________________

SIGNATURE INDICATES RECEIPT OF INFORMATION

By signing below, you acknowledge receipt or access to the following documents:

- □ *Notice of Privacy Practices* — provides information about how I may use and disclose your protected health information.
- □ *Telehealth Informed Consent Agreement and Disclosure* — explains the limitations of online counseling.
- □ *General Practice Informed Consent Agreement and Disclosure* — explains practice policies, including financial agreement.
- □ Your signature indicates that you have been informed about the fees for services and agreed to be responsible for such fees.

I encourage you to read each document in fully and carefully. Should any of the above information change, you will be informed and copies of the changes will be made available to you. If you have any questions, please let me know during our session or call 661-747-2469.

I acknowledge receipt of the above documents provided by Sue Speake, LMFT, LPCC.

Signature:______________________________ Date: ________________________________
(patient/parent/conservator/guardian)