# Tara Yardley LPC LLC

## Adult Intake Form

Client name: _____Home Phone: _____

Cell Phone: _____May we leave a message: YES NO

Email Address _____Can we use this for communications? YES NO

How May we contact you? (circle all that apply)

Home phone Cell Phone Work Phone Email Text Mail

Address:_____

City, State: _____ Zip code: _____

Date of Birth: _____Age: _____ Gender: _____

Employer: _____Phone: _____

Occupation: _____ Years of service: _____

Marital status: _____

Who can we thank for your referral? _____

Referral Address:_____

Emergency Contact _____Relationship _____

Phone _____ May we identify ourselves when we call ? YES NO

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## Insurance and Contact

Primary Insurance Company _____Contact Phone # _____

ID # _____Group # _____Employer _____

Name of Insured _____Relationship_____Date of Birth _____

Insured's Address _____City _____State__ _____ Zip Code _____

Secondary Insurance Company* _____Contact Phone # _____

ID # _____Group # _____Employer _____

Name of Insured _____Relationship _____Date of Birth _____

Insured's Address _____City /State/Zip Code_____

Responsible party, if other than client: Name _____Relationship _____

Address _____ City/State/Zipcode _____

Spouse's Name: _____ Phone number: _____

If questions arise, can we discuss financial matters with spouse or the Responsible party noted above? YES NO
Signature _____ Date: _____

"Copays and deductibles from primary insurance are due at the time of appointment. Secondary insurance will be billed in order to reimburse client payments. Medicaid will not be billed as secondary insurance to cover copays from primary insurance.

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**Behavioral Health Treatment History**

Have you ever seen a counselor/therapist before? YES NO

If yes, who did you see and dates _____

Are you currently taking any psychotropic medications (such as antidepressant, mood stabilizer, etc)? YES NO

If yes, please list medication and dosage _____

Who prescribed your medications? _____

Have you ever been hospitalized for emotional problems? YES NO

If yes, where? _____ What for? _____

Have you ever made a suicide attempt/gesture/threat? YES NO If so, when? _____

Explain circumstances _____

_____

_____

Are you currently experiencing Suicidal thoughts? YES NO

**Medical History**

Have you been hospitalized for medical concerns: Yes NO What for? _____

_____

Are you currently taking any physical medications? (List) _____

Who is your primary care Physician? _____ Date of last visit _____

Primary care physician phone number _____

Primary care physician address _____

_____

Name of other healthcare professionals currently treating you _____

Signature: _____ Date: _____