

Nichols Panorama Counseling LLC

Client Intake

Intake Appt: _____

Client Information:

Name (legal): _____ Date of Birth: _____

Preferred Name: _____ Age: _____

Administrative Sex: Male Female Gender (as listed with insurance): Male Female

Marital Status: single married divorced widowed other

Address: _____

Employment: unemployed part-time employed full-time employed student retired other

Contact Information:

please indicate if okay to leave text or voicemails related to:

Phone #: _____ Appointments: yes no Clinical information: yes no

Work #: _____ Appointments: yes no Clinical information: yes no

Email: _____ Appointments: yes no Clinical information: yes no

Would you like an email to join the Patient Portal which grants you free access to schedule or change future appointments? (Telehealth/Virtual Therapy is also held through the portal.) Yes No

Parent/Guardian Information (if client is a minor):

Name: _____ Phone #: _____ Relationship to Client: _____

Name: _____ Phone #: _____ Relationship to Client: _____

Others: _____ Phone #: _____ Relationship to Client: _____

Emergency Contact(s):

Name: _____ Phone #: _____ Relationship to client: _____

Name: _____ Phone #: _____ Relationship to client: _____

Clients Name: _____

Primary Care Physician:

Name: _____ Phone #: _____ Date of last physical: _____

Can Nichols Panorama Counseling LLC provide to or obtain information from your PCP? Yes No Unsure

Psychiatrist:

Name: _____ Phone #: _____ Date of last appointment: _____

Can Nichols Panorama Counseling LLC provide to or obtain information from your Psychiatrist? Yes No
Unsure

As necessary, we will discuss signing an Release of Information for communication between Mary Ann Nichols, LPC and your PCP and/or Psychiatrist. They will not be contacted without from signed authorization.

Payment and Insurance Information:

Person Responsible for Payment (ie. self, parent): _____

Insurance Company: _____ Policy Number: _____ Group: _____

Full Name of Insured: _____ Birthday of Insured: _____

Your Relationship to Insured: self spouse child other

By Signed below, you authorize Nichols Panorama Counseling LLC to file insurance claims using the above provided information. If your insurance changes, it is your responsibility to inform us of the change in order to avoid additional out of pocket expenses. A copy of the front and back of your insurance card must be provided.

Signature of Client or Guardian

Date

***Opt Out of use of Insurance:**

If you would prefer to not have claims submitted through your insurance, please let me know so an opt out form can be signed.

How did you find out about Nichols Panorama Counseling? _____

Clients Name: _____

Please answer the following as detailed or as little as you feel comfortable. Feel free to write on back of page if necessary. If there is an area you do not wish to discuss, please indicate.

Presenting Problems? How long have you been experiencing this?

Prior psychiatric symptoms and treatment:

Prior Psychiatric testing and/or diagnosis:

Trauma or Abuse History:

Current Medications (*please include name, dosage, and indication*):

Relevant Medical History:

Family Psychiatric/substance abuse History:

Current or Prior Drug/Alcohol Abuse:

Who is in your family? Relationship with them?

Who lives in the home? Is there conflicts or stress? Safety concerns at home?

How was your childhood, schooling, upbringing, etc?

Education and Employment history and current status:

Religious or Spiritual Beliefs:

Current or Prior Legal History:

What do you feel are your strengths?

What do you feel are your weaknesses? Possible barriers to treatment?

Who do you consider is in your support system?

Any other Relevant information you would like to share:
