SOLACE POINT
THERAPY

NEW CLIENT INTAKE FORM

Please fill out this new client intake form and bring it with you to your first session. Note: information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Date: _____

Name:_____ DOB: _____ Gender/Pronouns: _____

Parent/Legal Guardian (if under 18): _____

Address:_____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Relationship Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed □ Other

Emergency Contact Name:_____

Relationship: _____ Phone: _____

HISTORY

Have you received any type of mental health services (counseling, psychiatric services)? □ No □ Yes
Previous therapist/practitioner: _____

Are you currently taking any prescription medication for physical or mental health? □ Yes □ No
If yes, please list:

_____

_____

_____

_____

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GENERAL AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific physical problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you exercise? _____ What types of exercise? _____

_____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, how long?_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10 (1 = poor - 10 = exceptional), how would you rate your relationship? _____

11. Have you experienced any significant life changes or stressful events recently? □ No □ Yes

Please explain: _____

_____

_____

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FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (e.g. father, grandmother, uncle, etc.).

Alcohol/Substance Abuse □ No □ Yes – Family member_____

Anxiety □ No □ Yes – Family member_____

Depression □ No □ Yes – Family member_____

Domestic Violence □ No □ Yes – Family member_____

Eating Disorders □ No □ Yes – Family member_____

Obesity □ No □ Yes – Family member_____

Obsessive Compulsive Behavior □ No □ Yes – Family member_____

Schizophrenia □ No □ Yes – Family member_____

Suicide Attempts □ No □ Yes – Family member_____

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____
_____
Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____
_____

4. What do you consider to be some of your weaknesses? _____
_____

5. What would you like to accomplish out of your time in therapy? _____
_____
_____

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AUTHORIZATIONS

Financial responsibility for services at Solace Point Therapy, (Jerry Woodards, MSW, LICSW), rests between the patient and their insurance provider(s). Our office is happy to file medical insurance claims on your behalf, however, if patient's insurance provider denies a claim, the patient is still responsible for paying for all services in full.

You must pay any co-payment or applicable deductible amounts at the time of service unless other arrangements have been made with our office. The remainder of your bill will be sent to your health insurance company for direct payment to our office.

If your insurance carrier has not paid our claim within 45 days, we will expect payment from you. If, by mistake, your health plan remits payments to you, please send it to us along with all paperwork sent to you at the time.

Insurance may refuse payment of a claim if:

- This is an illness not covered by your plan.
- You have not met your full deductible for the calendar year.
- Your plan does not cover the type of medical service required.
- The health plan was not in effect at the time of service.
- You have other insurance that must be filed first.

Insurance Provider:_____ ID # _____

Insurance Company Address: _____

I acknowledge that I have read the above and understand my financial obligations and responsibilities. I have completed this form with accurate information. I acknowledge that I am fully responsible for supplying the correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Client Name: _____ Driver License # _____

Client Signature: _____ Date: _____