

**Mental Health Intake Information**

**Please complete all information on this form and bring it to the first visit.** It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

**Patient Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Current Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phones (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Place/type of Employment: \_\_\_\_\_

**Referral Source:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email (if available): \_\_\_\_\_

**Emergency Contact** (in the case of an emergency, please provide the name and contact information of a person

Regan Hager LMHC may notify)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to Client:

Patient's Spouse's name:  N/A. \_\_\_\_\_

Current Address:  Same as client, or \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Mother's Name:  N/A Client is not a minor \_\_\_\_\_

Current Address:  Same as client, or \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Father's Name:  N/A Client is not a minor \_\_\_\_\_

Current Address:  Same as client, or \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Does the Patient have any Children?**  Yes  No If yes, please list:

Name	Date of Birth/Age:
_____	_____
_____	_____
_____	_____

**Does the Patient have any Siblings?**  Yes  No If yes, please list:

Name	Date of Birth/Age:
_____	_____
_____	_____
_____	_____

**Patient's Primary Care Physician Name:** \_\_\_\_\_

Date of last Apt: \_\_\_\_\_

**Any other Healthcare Provider(s) :**  Yes  No If yes, Name and Type of Physician: \_\_\_\_\_

Date of last Apt: \_\_\_\_\_

**Presenting Problem**

What are the problem(s) for which you are seeking help?

\_\_\_\_\_  
\_\_\_\_\_

What are your treatment goals? What are you hoping to get out of therapy?

\_\_\_\_\_  
\_\_\_\_\_

What is the main reason you are seeking services?

\_\_\_\_\_  
\_\_\_\_\_

Are there any recent changes in your life?  Yes  No If yes, How have these changes affected you?

\_\_\_\_\_  
\_\_\_\_\_

**Current Symptoms Checklist: (check all that apply)**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Depressed mood     | <input type="checkbox"/> Racing thoughts  | <input type="checkbox"/> Excessive worry           | <input type="checkbox"/> Unable to enjoy activities  |
| <input type="checkbox"/> Impulsivity        | <input type="checkbox"/> Anxiety attacks  | <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior     |
| <input type="checkbox"/> Avoidance          | <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido          | <input type="checkbox"/> Decrease need for sleep     |
| <input type="checkbox"/> Hallucinations     | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Suspiciousness            | <input type="checkbox"/> Concentration/forgetfulness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Excessive guilt           | <input type="checkbox"/> Increased irritability      |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Crying spells    | <input type="checkbox"/> _____                     | <input type="checkbox"/> _____                       |

What are some of your strengths?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever attempted suicide?  Yes  No If yes, When: \_\_\_\_\_ How: \_\_\_\_\_

Do you currently have or have you recently had thoughts of harming yourself?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever attempted to harm yourself?  Yes  No If yes, When: \_\_\_\_\_ How: \_\_\_\_\_

Do you currently have or have you recently had thoughts of harming another person  Yes  No

If yes, describe: \_\_\_\_\_

**Patient Health History:**

Do you have any current or chronic health issues? Yes  No  If yes, please list: \_\_\_\_\_

Are you currently taking any medication?  Yes  No If yes, please list:

Type:	Start Date:	Dosage:	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications or supplements:

\_\_\_\_\_  
\_\_\_\_\_

**Family Medical History (Current or past):**

	Patient <input type="checkbox"/>	Mother <input type="checkbox"/> Unknown	Father <input type="checkbox"/> Unknown
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung problems (asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Miscarriages	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinking problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic violence(victim)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Past Psychiatric History:**

**Previous Counseling**  Yes  No If yes, Please describe when, by whom, and nature of treatment.  
 Reason Dates Treated By Whom

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**Psychiatric Hospitalization**  Yes  No If yes, describe for what reason, when and where Hospitalized

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**Past Psychiatric Medications (Check all that apply):** If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember, just write in what you do remember).

Antidepressants	Date:	Dosage:	Response to Medication
<input type="checkbox"/> Prozac (fluoxetine)	_____	_____	_____
<input type="checkbox"/> Zoloft (sertraline)	_____	_____	_____
<input type="checkbox"/> Luvox (fluvoxamine)	_____	_____	_____
<input type="checkbox"/> Paxil (paroxetine)	_____	_____	_____
<input type="checkbox"/> Celexa (citalopram)	_____	_____	_____
<input type="checkbox"/> Lexapro (escitalopram)	_____	_____	_____
<input type="checkbox"/> Effexor (venlafaxine)	_____	_____	_____
<input type="checkbox"/> Cymbalta (duloxetine)	_____	_____	_____
<input type="checkbox"/> Wellbutrin (bupropion)	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

Antipsychotics/Mood Stabilizers	Date:	Dosage:	Response to Medication
<input type="checkbox"/> Seroquel (quetiapine)	_____	_____	_____
<input type="checkbox"/> Zyprexa (olanzapine)	_____	_____	_____
<input type="checkbox"/> Geodon (ziprasidone)	_____	_____	_____
<input type="checkbox"/> Abilify (aripiprazole)	_____	_____	_____
<input type="checkbox"/> Clozaril (clozapine)	_____	_____	_____
<input type="checkbox"/> Haldol (haloperidol)	_____	_____	_____
<input type="checkbox"/> Risperdal (risperidone)	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

ADHD medications	Date:	Dosage:	Response to Medication
<input type="checkbox"/> Adderall (amphetamine)	_____	_____	_____
<input type="checkbox"/> Concerta (methylphenidate)	_____	_____	_____
<input type="checkbox"/> Ritalin (methylphenidate)	_____	_____	_____
<input type="checkbox"/> Strattera (atomoxetine)	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

Antianxiety medications	Date:	Dosage:	Response to Medication
<input type="checkbox"/> Xanax (alprazolam)	_____	_____	_____
<input type="checkbox"/> Ativan (lorazepam)	_____	_____	_____
<input type="checkbox"/> Klonopin (clonazepam)	_____	_____	_____
<input type="checkbox"/> Valium (diazepam)	_____	_____	_____
<input type="checkbox"/> Tranxene (clorazepate)	_____	_____	_____
<input type="checkbox"/> Buspar (buspirone)	_____	_____	_____

**Family Psychiatric History:**

Has anyone in your family been diagnosed or treated for any of the following: (Check all that apply)

- |   |  |                                     |                                   |  |
|---|--|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Post-traumatic stress |
| <input type="checkbox"/> Alcohol abuse    | <input type="checkbox"/> Anger         | <input type="checkbox"/> Suicide    | <input type="checkbox"/> Violence | <input type="checkbox"/> Other substance abuse |

If yes, who had each problem? \_\_\_\_\_

**Substance Use:**

Have you ever been treated for alcohol or drug use or abuse?  Yes  No

If yes, for which substances? \_\_\_\_\_

If yes, where were you treated and when? \_\_\_\_\_

Do you think you may have a problem with alcohol or drug use?  Yes  No

Have you used any street drugs in the past 3 months?  Yes  No

If yes, which ones? \_\_\_\_\_

**Tobacco History:**

How you ever smoked cigarettes?  Yes  No

Currently?  Yes  No How many packs per day on average? \_\_\_\_\_ How many years? \_\_\_\_\_

In the past?  Yes  No How many years did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Pipe, cigars, or chewing tobacco:** Currently?  Yes  No In the past?  Yes  No

What kind? \_\_\_\_\_ How often per day on average? \_\_\_\_\_ How many years? \_\_\_\_\_

**Educational History:**

Highest Grade Completed? \_\_\_\_\_ Where? \_\_\_\_\_

Did you attend college? \_\_\_\_\_ Where? \_\_\_\_\_ Major? \_\_\_\_\_

What is your highest educational level or degree attained? \_\_\_\_\_

**Occupational History:**

Are you currently:  Working  Student  Unemployed  Disabled  Retired

How long in present position? \_\_\_\_\_

What is/was your occupation? \_\_\_\_\_

Where do you work? \_\_\_\_\_

Have you ever served in the military? \_\_\_\_\_ If so, what branch and when? \_\_\_\_\_

Honorable discharge ( ) Yes ( ) No Other type discharge \_\_\_\_\_

**Relationship History and Current Family:**

Are you currently:  Married  Partnered  Divorced  Single  Widowed

**Legal History:**

Have you ever been arrested? \_\_\_\_\_

Do you have any pending legal problems? \_\_\_\_\_

**Spiritual Life:**

Do you belong to a particular religion or spiritual group?  Yes  No

If yes, what is the level of your involvement? \_\_\_\_\_

Do you find your involvement helpful during difficult times, or does the involvement make things more difficult or stressful for you?  more helpful  stressful

Is there anything else that you would like me to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Regan Hager LMHC**  
**(850) 462-3595 Fax: (850) 607-2771**  
**ReganHagerLMHC@gmail.com**  
**CONSENT TO TREATMENT**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, the Patient (or legal guardian of the minor patient) \_\_\_\_\_, hereby voluntarily consent to outpatient mental health services from Regan Hager LMHC which encompasses assessments and subsequent therapeutic treatments, if indicated.

I understand and agree that all charges incurred on behalf of my care are my responsibility. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies

I authorize any holder of medical or other information about me to be released to Electronic Data Systems, Federal, Department of Public Health or other carriers any information needed for any related claim. I permit a copy of this authorization to be used in place of the original to request payment of medical benefits.

I, the undersigned, authorize payment of medical benefits to Regan Hager LMHC for any services furnished to me by the mental health therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration, Social Security Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I understand that this consent form will be valid and remain in effect as long as I receive services from Regan Hager LMHC.

HIPPA/Notice of Privacy Practices: By signing below, I understand that the information contained within this document pertains to certain rights to how my protected health information is utilized in the treatment, payment and healthcare operations at this facility.

I understand that, if I am more than 15 minutes late for a scheduled session, I may not be able to be seen by my clinician on that day.

Please check any method of communication that is **not** acceptable for us to contact you:

Phone       Text Message       E-mail       Physical Mail

This form has been explained to me and I fully understand this **Consent To Treatment** and agree to its contents.

**Signature of Patient or Person Authorized to consent for patient:**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Clinician(Name and Credentials) who explained the contents of this "Consent to Treatment" form:**

\_\_\_\_\_ Date: \_\_\_\_\_

- I have seen and been offered a copy of HIPPA's Patient's Bill of Rights and Privacy Policies
- I have seen and been offered a copy of Regan Hager LMHC's Client's Bill of Rights (Available in office and on [www.Pensacolacounselor.com](http://www.Pensacolacounselor.com))

**Cancellation and Financial Policy**

Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **48 hours notice** if you are unable to keep your scheduled appointment. This affords the opportunity to reschedule the time block should a scheduling conflict arise. IF YOU DO NOT CANCEL YOUR APPOINTMENT 48 HOURS BEFORE THE TIME OF YOUR SCHEDULED APPOINTMENT, YOU WILL BE BILLED YOUR FULL SESSION FEE (\$150) AS AGREED UPON.

**CREDIT CARD AUTHORIZATION**

Regan Hager, LMHC, requires a credit card authorization be on file so that your balances can be settled as they occur. If you chose, this can also be your regular form of payment. When credit card charges for unpaid balances arise (e.g., missed appointments), a statement of the charges and receipt will be E-mailed and/or mailed to you upon request.

I authorize Regan Hager, LMHC, to record the below credit/debit card information and any additional payment devices I use for services with Regan Hager, LMHC, and to use this information to collect outstanding balances on my/our account. I understand that when I provide a credit or debit card that does not have my name imprinted on it, by signing this authorization and charge receipts I am acknowledging that I am an authorized user of that account. I understand that I may revoke authorization of a payment device in writing and that eligibility of services may be terminated unless a valid form of payment is on file. Also, if there are updates to your card over time and you choose to have Regan Hager, LMHC update those changes on this form, you acknowledge and consent to those modifications being amended without need for another signature. You may also reprint this form and provide it to Regan Hager, LMHC if you prefer.

In addition to cancellation fees and no show fees, I approve the card below be utilized as a form of payment for session fees and/or copayments. Yes No

Type of card :            Visa                    MasterCard            Discover            American Express

Is this a debit card?                                    Yes            No

Credit Card Number:  
\_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

3 digit (4 digit for AMEX) CVV/CVC number\* \_\_\_\_\_

\* This CVV/CVC number is printed on MasterCard & Visa cards in the signature area of the back of the card. It is the last 3 digits AFTER the credit card number in the signature area of the card. For American Express cards, the 4 digit number is located on the front of the card.

Expiration Date (mm/yy): \_\_\_\_\_            Billing Zip Code: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

## **Limits of Confidentiality**

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

### **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

### **Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

### **Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

### **Insurance Providers (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_  
Signature of Patient or Parent / Guardian if client is a minor

\_\_\_\_\_  
Date