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

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: _____

Tricare Insurance Number (If applicable):_____

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:
_____	_____
_____	_____
_____	_____

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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?

1._____
2._____
3._____

What are your treatment goals?

1._____
2._____
3._____

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)

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

What are some of your strengths?

_____

What are some of your limitations?

_____

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:

Does the patient have any current or chronic health issues? ☐ Yes ☐ No If yes, please list:

_____

Is the patient currently taking any medication? ☐ Yes ☐ No If yes, please list:

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

Current over-the-counter medications or supplements:

_____	_____	_____	_____
_____	_____	_____	_____

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Family Medical History (Current or past):

	Patient ☐ Unknown	Mother ☐ Unknown	Father ☐ Unknown
High blood pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lung problems (asthma)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Miscarriages	☐ Yes ☐ No	☐ Yes ☐ No	
Learning problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mental illness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Drinking problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Domestic violence(victim)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Past Psychiatric History:

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

_____

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

_____

_____

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

☐ Prozac (fluoxetine) _____
☐ Zoloft (sertraline) _____
☐ Luvox (fluvoxamine) _____
☐ Paxil (paroxetine) _____
☐ Celexa (citalopram) _____
☐ Lexapro (escitalopram) _____
☐ Effexor (venlafaxine) _____
☐ Cymbalta (duloxetine) _____
☐ Wellbutrin (bupropion) _____
☐ Other _____

Antipsychotics/Mood Stabilizers Date: Dosage: Response to Medication

☐ Seroquel (quetiapine) _____
☐ Zyprexa (olanzepine) _____
☐ Geodon (ziprasidone) _____
☐ Abilify (aripiprazole) _____
☐ Clozaril (clozapine) _____
☐ Haldol (haloperidol) _____
☐ Risperdal (risperidone) _____
☐ Other _____

ADHD medications Date: Dosage: Response to Medication

☐ Adderall (amphetamine) _____
☐ Concerta (methylphenidate) _____
☐ Ritalin (methylphenidate) _____
☐ Strattera (atomoxetine) _____
☐ Other _____

Antianxiety medications Date: Dosage: Response to Medication

☐ Xanax (alprazolam) _____
☐ Ativan (lorazepam) _____
☐ Klonopin (clonazepam) _____
☐ Valium (diazepam) _____
☐ Tranxene (clorazepate) _____
☐ Buspar (buspirone) _____

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Family Psychiatric History:

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

☐Bipolar disorder ☐ Schizophrenia ☐Depression ☐Anxiety ☐ Post-traumatic stress
☐Alcohol abuse ☐Anger ☐Suicide ☐Violence ☐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 us to know?

_____
_____
_____
_____
_____
_____

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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 here are my responsibility. I understand that if I have insurance, it will be billed as a courtesy and payments/credits from my insurance company will be made accordingly.

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 determent 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 Witness (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

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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 24 HOURS BEFORE THE TIME OF YOUR SCHEDULED APPOINTMENT, YOU WILL BE BILLED YOUR FULL SESSION FEE($110) AS AGREED UPON. ALL OTHERE CANCELATIONS WITHIN THE 48 HOURS PRIOR TO A SCHEDULED SESSION WILL BE ASSESSED A $35 FEE.

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. (Circle one) Yes No

Type of card (Circle one): Visa MasterCard Discover American Express Is this a debit card? (Circle one) Yes No

Credit Card Number:

_____

Name as it appears on card:_____

3 digit (4 digit for AMEX) CVV/CVCnumber*_____

* 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:_____

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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