Patient Name: Intake Date:

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Kenfield Walters Intl LLC
PH. (248) 737-0388

New Patient Information: Adult Form

Last:	First:	Middle:
DOB:	Sex: ☐M ☐F	SS#:
Home Ph.:	Cell:	**Email:**
Address St.:	City:	Zip:
	Emergency **Contact**	
Last:	First:	Relationship: Ph. #:
	Insurance Information	
Primary Insurer:	ID:	Group #:
Secondary Insurer:	ID#:	Group #:
Policy Holder:	Relationship:	DOB:
SS #:	Employer:	Ph #:
	Office Use Only	
Type of Treatment: ☐ **XCBT** ☐ **Insight** ☐**X Behavioral** ☐ **Supportive**	**Deductibles and co-pays are due at the time services are rendered.**	**DX:** **F Code:**
Billing Office Use Only : Benefit Verification Information	☐ **Individual** ☐ **Family** ☐ **Group**	**Functioning:** **Poor, Fair, Good, Very good**
Policy Effective Date:	☐ **Calendar year plan** ☐ **Monthly plan**	
Copay: $	**Deductible: $**	**Deductible Remaining: $**
Visit Limitation:	**Authorization #:**	**Start/End Date:**
Intake Date:	**Appointment Time:**	**Clinician: J.C. Walters, Ph.D.**
Clinician Signature:		**Date:**
MEDICAL CONCERNS:		
REASON FOR APPOINTMENT:		

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Financial Policies

Payment of services is considered a part of your treatment and is expected at each session. WE accept most insurances and provide a Pay Pal button on the "Insurance and Billing" page of our website: www.KenfieldWalters.com so that the option to use a credit or debit card is available to you 24/7. Make checks payable to "Kenfield Walters Intl LLC."

KWI accepts most insurances but each patient is responsible for payment of services in full at the time that services are rendered until the annual deductible, if applicable, is fully paid, and for co-payments at each session as stipulated in the insurer benefit package.

Please initial in the designated places to signify that you have read and agree to each of the policies below:

X_____ I agree to a charge of $60.00 for missed appointments and for cancellations given within less than a 48-hour notification.

X_____ I agree to pay immediately a $35.00 "returned check fee" in addition to replacing the amount of a check returned by my bank.

X_____ I agree to report to KWI any changes in my contact information (address, phone #, etc.), insurance, or responsible party prior to the next session appointment.

X_____ I agree that if my account remains unpaid for more than 90 days, and/or exceeds $200, KWI may add a 1.50% service charge not exceeding 1.50% per month to any balance not received by the *date due* and KWI may take legal action to collect the balance. I agree, as my sole responsibility, to pay all attorney fees and court costs for both parties in any dispute.

X_____ I understand that I am financially responsible for services provided, whether reimbursed by my insurer or not. Any service charges not covered by my insurer are my responsibility. Additional service fees are published below:

A FEE MAY BE CHARGED FOR ADDITIONAL SERVICES	
X Patient Initials:	**Date:**

Initialed Acknowledgement of Receipt of HIPAA Privacy Practices
X_____ I hereby **initial** here to acknowledge that I have been apprised of the availability of a copy of Kenfield Walters Intl LLC "Privacy Policy" that can be downloaded in its entirety at http://www.kenfieldwalters.com on the "New Patient Forms" page."

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Initialed Consent for Treatment

X_____ hereby consent to receive treatment for therapeutic/psychological services through Kenfield Walters Intl LLC. I have been notified that the "Consent for Treatment" form can be downloaded at http://www.kenfieldwalters.com on the "New Patient Forms" page."

Office Use Only:

We attempted to obtain written acknowledgement of the availability of our Privacy Practices and for Consent for Treatment for the following:
☐ Individual refused to sign.
☐ Communication barriers prohibited obtaining an acknowledgement.
☐ An emergency prevented us from obtaining acknowledgement.
☐ Other (specify):_____

Initialed Coordination of Care with Primary Care Physician

I, X (Patient Initials) _____ ☐ Authorize / ☐ Do Not Authorize, the release of any information to my physician by Kenfield Walters Intl LLC and the release of any information to Kenfield Walters Intl LLC by:

Physician Name:	Ph. #:	Fax #:

Address:	City:	MI	Zip:

X Patient/Guardian Signature:	X Date:

Please check Current symptoms:

☐ Anger	☐ Hyperactivity
☐ Anxiety	☐ Irritability
☐ Appetite Change	☐ Mood Swings
☐ Crying Spells	☐ Paranoia
☐ Decreased Concentration	☐ Racing Thoughts
☐ Excessive Worry	☐ Sleep Problems
☐ Feeling Hopeless	☐ Suicidal Feelings
☐ Weight Change	☐ Homicidal Thoughts
☐ Depression	☐ Overwhelmed
☐ Delusions	☐ Hallucinations
☐ Self-esteem issues	☐ Grief/loss

Current concerns:

☐ Abuse History: _____
☐ Academic Issues
☐ Behavior Issues
☐ Financial Problems
☐ Health Issues
☐ Legal Issues
☐ Grief/Loss
☐ Relationship Issues
☐ Sexual Issues
☐ Substance Abuse: _____
☐ Work Issues

Patient Mental Health Questionnaire – Circle one answer/number for each question.

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Over the past two weeks, how often have you been troubled by any of the following problems?				
	Not at all	**Several days**	**More than half of the time**	**Nearly every day**
1. Little interest in doing things.	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep.	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5. Poor appetite or overeating.	**0**	**1**	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading.	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead, or hurting yourself.	**0**	**1**	**2**	**3**
Office Use Only: Column Totals				

SOCIAL INFORMATION

1. Do you usually spend leisure time: ☐ Alone ☐ With family ☐ With friends

2. Describe your strengths: _____ _____ _____ _____

3. List your hobbies: _____ _____ _____
_____

SUICIDAL ISSUES

1. Have you ever thought about suicide? ☐ No ☐ Yes

2. Do you have a history of suicide attempts? ☐ No ☐ Yes Date of most recent if yes: _____

How?: _____

3. Do you currently feel suicidal? ☐ No ☐ Yes Explain: _____

EDUCATION

☐ Did not complete High School ☐ High School Diploma ☐ GED ☐ Vocational Training
☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate / Psy D. ☐ MD/DO
School: _____ Major: _____ Final GPA: _____

1. Have you experienced academic difficulties? ☐ No ☐ Yes If, yes, When ?:_____

2. Have you experienced behavior problems in school? ☐ No ☐ Yes _____

OCCUPATION

☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed

☐ Employed Name of Employer: _____ Job Title: _____

Primary Sources of support: ☐ Self-support ☐ Full/Part Time Job ☐ Parents ☐ Spouse
☐ Retirement ☐ Disability

Have you ever been in the military? ☐ No

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□ Yes: □ Army □ Air Force □ Coast Guard □ Navy □ Marines

Enlistment Date: _____ (Circle): Honorable / Dishonorable Discharge Date: _____

FAMILY INFORMATION

Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widow(er)

Children: □ I do not have children

Name	Age	Biological/Step/Adopted	Lives with you?
SPOUSE:			□ No □ Yes
Children:			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
SIBLINGS:			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes
			□ No □ Yes

Describe your relationships with family members:

At Childhood: □ Poor □ Strained □ Good □ Excellent
At Adulthood: □ Poor □ Strained □ Good □ Excellent
At Present: □ Poor □ Strained □ Good □ Excellent

Were you raised in a home that practiced a religion? □ No □ Yes
Do you currently practice a religion? □ No □ Yes
□ Catholic □ Christian □ Hindu □ Jewish □ Protestant □ Muslim □ Other: _____

Ethnic Group:

□ African-American/Black □ Asian □ Caucasian □ Hispanic □ Native American
□ Other: _____

LEGAL HISTORY

(Circle) Are you currently and/ or have been in the past involved in a:

□ Custody Suit, Date: _____ □ On Probation, Date(s): _____

□ DUI/OWI Conviction(s), Date(s): _____ □ Divorce(s), Date(s): _____

□ Other: _____

MEDICAL HISTORY

Describe Your current health:	Are you experiencing physical pains at this time?
□ Poor □ Fair □ Good □ Very good	□ No □ Yes: Where? _____

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Check all that apply to yourself or an immediate family member:			
	Myself - Insert Dates Below		**Family Member**
	Current/Recent	**Past**	□ Mother □Father □Sibling
Abuse: Emotional/Physical/Sexual			□ Mother □Father □Sibling
Alcohol Abuse…&/or Inpatient hospitalization…			□ Mother □Father □Sibling □ Mother □Father □Sibling
ADD/ADHD			□ Mother □Father □Sibling
Anxiety			□ Mother □Father □Sibling
Asthma			□ Mother □Father □Sibling
Appendicitis			□ Mother □Father □Sibling
Bed wetting			□ Mother □Father □Sibling
Birth defects			□ Mother □Father □Sibling
Bulimia			□ Mother □Father □Sibling
Cancer			□ Mother □Father □Sibling
Chest pain			□ Mother □Father □Sibling
Constipation			□ Mother □Father □Sibling
Chicken Pox			□ Mother □Father □Sibling
Diabetes			□ Mother □Father □Sibling
Diarrhea			□ Mother □Father □Sibling
Fainting			□ Mother □Father □Sibling
Hearing			□ Mother □Father □Sibling
High blood pressure			□ Mother □Father □Sibling
Migraines			□ Mother □Father □Sibling
Nausea			□ Mother □Father □Sibling
Psychiatric hospitalization			□ Mother □Father □Sibling
Stroke			□ Mother □Father □Sibling
Other hospitalization(s)			□ Mother □Father □Sibling
Other Issues:			□ Mother □Father □Sibling

MEDICATION LOG

List Prescribed or over-the-counter medication(s) or herbal supplements you currently take:

Medication	**Dosage**	**Frequency**	**Prescriber**

Allergies/Side Effects:

_____ _____ _____ _____

MEDICAL HISTORY CONTINUED

List any major accidents or surgeries: □ Not applicable

Surgeries(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Accidents(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Do you have any diet or nutritional concerns: □ No □ Yes: _____

Have you gained weight in the last 60 days: □ No □ Yes: _____

Have you lost weight in the last 60 days: □ No □ Yes: _____

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Do you ever: ☐ overeat ☐ induce vomiting ☐ Use laxatives ☐ Exercise to get rid of calories ☐ Skip meals

SUBSTANCE USE

ALCOHOL USE:
Do you currently drink? ☐No ☐ Yes What is your consumption weekly?

Have you ever been told to cut down on your drinking? ☐ No ☐ Yes

Have you ever felt bad about your drinking habits? ☐ No ☐ Yes

Have you ever attended an AA group? ☐No ☐ Yes: When: _____

Have you ever been convicted of an: ☐MPI ☐DWI ☐ OWI? When? _____ _____ _____

Have you been treated as an *outpatient* for alcohol use: ☐ No ☐Yes - Dates:_____ Therapist: _____

Have you been treated as an *inpatient* for alcohol use? ☐ No ☐Yes - Dates: _____ Facility?_____

DRUG USE
Do you / have you use/(d) illegal drugs, or non-prescription medication now or in the past? ☐ No ☐ Yes

Drugs Used: ☐ Amphetamines ☐ Crack/Cocaine ☐ Heroine/Opiates ☐ Marijuana ☐ Over-the-counter

Have you ever attended an NA meeting? ☐ No ☐ Yes Date(s):_____

Have you ever been treated as an *outpatient* for drug use? ☐No ☐Yes Date(s): _____

Have you ever been treated as an *inpatient* for drug use? ☐ No ☐Yes Date(s):

CAFFEINE USE: ☐ Not applicable
Coffee: Cups per day ☐ 1 ☐2 ☐3 ☐4+

Tea: Cups per day: ☐1 ☐2 ☐3 ☐4+

Energy Drinks: ☐1 ☐2 ☐3 ☐4+

SMOKING: Check the response that best summarizes your cigarette smoking status:

☐ Never smoked ☐ Former smoker: Month/Year Quit: _____

☐ Current Smoker: Average number of cigarettes smoked per day: _____

THERAPY GOALS

Please list what you hope to accomplish during therapy

1.

2.

3.

X_____ **Date:** _____
Patient/Guardian Signature