Newtown Psychotherapy Center
115 Pheasant Run
Suite 215
Newtown, PA 18940

Intake Form **Date**_____

Please provide the following information for our records.

Name: _____

Full Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Cell Phone: ( ) - May we text? ☐ Yes ☐ No
May we leave a message? ☐ Yes ☐ No

E-mail Address: _____
May we send you an email? ☐Yes ☐ No

Birth Date: ____/____/_____ Age: _____ Gender: _____

Emergency contact: _____
(Name) (Number) (Relationship)

Office Use Only

Counselor: _____
Dx: _____
Service: _____
R S: _____

Marital Status: Never Married Married Partnered Separated
 Divorced Widowed

Number of Marriages: _____ Number of Children: _____

Ages of Children: _____

What is your primary reason for coming to counseling?

_____
_____
_____
_____
_____

Health History:

Are you currently under the care of another professional counselor or psychiatrist?
 Yes No

Have you had previous counseling?
 Yes No If yes, please provide the therapist's name: _____
_____

Are you currently taking prescribed psychiatric medication, (antidepressants or others)? Yes No If yes, please list: _____

Have you been prescribed psychiatric medication in the past? Yes No
If yes, please list: _____

How is your physical health at this time?
 Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc):

_____

Are you currently under a doctor's care? Yes No

If yes, please provide the doctor's name: _____

Please list medications: _____
_____
_____
What was the date of your last medical exam? _____

Are you having difficulties sleeping? □ Yes □ No

If yes, check where applicable: □ Trouble falling asleep □ Frequent awakening

□ Disturbing dreams □ Sleeping too much □ Sleeping too little

□ Other _____

How many times per week do you exercise? _____ For how long? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No
If yes, please explain: _____

Have you had a significant weight change over the last two months? □ Yes □ No

Do you drink? _____ How much? _____

Any alcohol abuse in family of origin or present family? _____
Do you smoke? _____ Do you take drugs? _____
If yes, what kind and how often? _____

More information:
_____
_____
_____
_____
_____

Do you presently have suicidal thoughts?

 Frequently Sometimes Rarely Never

Have you had suicidal thoughts in the past?
 Frequently Sometimes Rarely Never

Educational Information:

What is your highest educational level or degree attained? _____

Name of School? _____

What type of degree? _____

What was your major? _____

Occupational Information:

Are you currently employed? Yes No
If yes, where? _____

What kind of work do you do? _____ How long? _____

How are things on the job? _____

If unemployed describe the situation:
_____
_____
_____
_____
_____

Religious/Spiritual Information:

What was your religious upbringing? _____

Present affiliation? _____

Is your religion an important part of your life? Yes No

Family System Information:

Where were you born? _____

Parents: Father alive? _____ Describe relationship_____
Mother alive?_____ Describe relationship _____

Siblings: 1) _____ Describe relationship_____
2) _____ Describe relationship_____
3) _____ Describe relationship_____

Domestic violence: _____

Sexual Abuse: _____

Parents divorced? ☐ Yes ☐ No If yes, what was your age at the time? _____

In general, how would you describe your childhood?

_____
_____
_____

Hobbies/ Interests:

What hobbies or activities do you enjoy?

_____
_____
_____

Other Information you would like us to know:

_____
_____
_____

INFORMED CONSENT AND AGREEMENT FOR THERAPY

Welcome! Thank you for entrusting us with the opportunity to work with you in therapy. Commitment to the therapeutic process exists most often because people want relief in the areas of their lives where he or she is facing discomfort and conflict. You may be experiencing an array of feelings that you want to understand and/or change. You may be looking to review your life choices so you can redirect your behavior and restore faith in yourself. Please be aware that there are times in the course of working together when you may report feeling worse before feeling better. Our objective is to find ways to restore your hope and to invest in yourself, maximize your strengths, and reach healthy, realistic, achievable goals.

PAYMENT FOR SERVICE
Clients are expected to pay for service at each session. To ensure that we utilize our time effectively, it is recommended that you write your check prior to the session to get the most value of our time together.

Therapy sessions are usually forty-five or fifty minutes in length. Time we spend on the phone is generally not billed because phone calls are usually short and are used for reporting an emergency or for setting up or changing session times. If, however, the calls are for the purpose of working on issues, extending a therapy session, or clarifying an insight and last more than 30 minutes, these calls will be pro-rated and billed as therapy time.

CANCELLATION POLICY
When we schedule an appointment, the time is reserved just for you. In consideration of other clients seeking an appointment and your therapist's time, we ask that, if you need to miss or cancel our session, you do so at least 24 hours before your scheduled time. You will be responsible for payment of $25.00 for missed or canceled sessions, less than 24 hours before the appointment time. _____

CONFIDENTIALITY (See Notice of Privacy Practices)
Information disclosed is considered confidential according to the laws of the State of Pennsylvania. In Pennsylvania, therapists are mandated to breach confidentiality in the following situations:

The therapist suspects serious suicidal intent.
The therapist suspects serious intent to harm others.
The therapist suspects abuse or neglect of a minor or an elder.
The therapist is subpoenaed by a court of law for records or to appear. We will make every effort to inform you prior to any mandated breach of confidentiality.

CONSULTATION WITH OTHER CLINICIANS
In the course of treatment it might be beneficial for us to discuss your situation with another therapist, psychiatrist, or physician for consultation or for supervisory purposes only. We will keep your name and identifying information confidential, and will make every effort to obtain your permission before discussing any information about you.

In the unlikely event that your therapist should become incapacitated, a trusted colleague will assume possession of the confidential records and perform such practical responsibilities such as notifying you and referring another therapist.

USE OF ELECTRONIC MEDIA
Psychotherapy, like all other health care, is by definition a private matter. Therefore, by signing this document,

we mutually agree that it is our intention to take every precaution to protect your privacy. Because any and all electronic media are subject to interception, the use of electronic media to communicate with me such as email, cell phone conversations and texting, list serves, Skype, Facebook, LinkedIn, and other social media compromises your privacy.

Communication between us will occur in person within the confines of our face-to-face sessions. Should it be necessary to communicate outside of face-to-face sessions or between sessions by cell phone, text or e-mail, we both understand and know that this communication can be intercepted or hacked into. In that regard, please know that in order for me to protect your privacy, we will avoid communication with you through social media such as Facebook, Skype, or LinkedIn.

Please Note: If you willfully initiate/engage in communication with us through e- mail, texting, cell phone usage and the like, you do so knowingly and with the full understanding that you may be compromising your privacy. This includes initial emails through our website, Psychology Today, and general e-mail usage.

EMERGENCY PROCEDURES
After normal business hours we may be difficult to reach. If we are out of telephone reach and you are in great need, please use the nearest hospital emergency room for more imminent service.

TERMINATION
When you have reached your therapy goals, termination is the natural next step. Should a further need arise, additional sessions are always available.

If during the course of your treatment, you or your therapist, believe that you are not being helped, we have an ethical responsibility to refer you to another therapist who might be a better fit and/or be better able to meet your needs.

If during the course of treatment you are unable to pay the fee, we will discuss your financial situation and, if possible, we will either reduce your fee or work to refer you to another clinician.

I have read and understand the above policies.

Signature_____ Printed Name _____ Date_____

Signature_____ Printed Name _____ Date_____