Main Street Counseling and Play Therapy, LLC

Adult Intake Form

Your Name: ___________________________________

Address: __________________________________City_____________State ________Zip__________

Email Address: ____ Phone: _____________________

D.O.B ____/_____/___________ Age: ______ Gender: ______

Primary MD: ______________________________ Who referred you: __________________________

MENTAL HEALTH HISTORY

Previous Mental/Behavioral Health Providers:

Name: __________________________ Dates: __________Issues or Diagnosis: _________________________

Name: __________________________ Dates: __________Issues or Diagnosis: _________________________

Any Suicidal verbalizations ___ Yes ___No Specify: ____________________________________

Suicide attempts ___ Yes ___No Specify: ____________________________________

Hospitalizations: ___ Yes ___No Specify: ____________________________________

List any history or suspicion of mental illness or addiction in immediate or extended family
(E.g. depression, anxiety, suicide attempts/completions, ADHD, alcoholism, drug abuse, etc.):

____

MEDICAL HISTORY

How would you describe your health? Very Good Good Fair Poor Very Poor

Have you had any other medical problems, illness, injuries, surgeries, or hospitalizations?
Yes No If yes, specify: ____

Are you taking any medications, including over the counter and vitamins?

Name:	Dose:	Frequency:
____________________________	_____________________	_________________________________
____________________________	_____________________	_________________________________
____________________________	_____________________	_________________________________

Past medications tried and reasons stopped: ____

____

TRAUMA HISTORY

Have you ever been verbally, physically, or sexually abused? Yes No Suspected

Specify: ____

Other stressors or traumas (e.g. death of love one, car accident, medical procedure, tornado, earthquake):

____

____

BEHAVIOR SYMPTOMS

Check any issues that apply:

- Anger
- Anxiety
- Controlling
- Depression
- Homicidal Thoughts/Action
- Dissociates
- Hyperactivity/Impulsivity
- Hypervigilance
- Impaired Concentration
- Lack of Empathy
- Legal Problems
- Lack of Motivation
- Low Self-Esteem
- Lying
- Nightmares
- Night Terrors
- Obsesses
- Suicidal Thoughts/Actions
- Self-Harm/ Cutting
- Peer Problems
- Phobias
- Aggression:
  - Physical Verbal
- Shy
- Startles Easily
- Stealing
- Sleep problems
- Tantrums

SUBSTANCE USE

Any substances abuse you have tried or are currently struggling : ____________________________________

Frequency:_______________________

Quantity:________________________

Consequences:______________________

____

THERAPUETIC GOALS

What are the current concerns? Please list in order of importance:

1. ____
2. ____
3. ____

What are your favorite activities, hobbies, and how do you spend your free time?

____

What are your strengths?

1. ____
2. ____
3. ____
4. ____

Briefly, what are your goals for therapy? How will you know when we have reached those goals?

____

____

____

What other information do I need to know about you or your family situation? ______________________

____

____

Name of the person completing form: ____________________________ Relation: ___________________

Signature: ____ Date: _________________________

Main Street Counseling and Play Therapy, LLC

Medical Insurance Information

Name of insured: ______________________________________ D.O.B. _____________________

Policy Holder Name: ___________________________________ D.O.B.____________________

Insurance Company: ___________________________

Relationship to patient: _________________________

Deductible: ________________ Copay: _______________________

Policy I.D. #: _________________________________ Group/Plan #: ____________________________

Phone # of Insurance Company for Pre-Certification: ____

Secondary coverage:

Policy Holder Name: ___________________________________ D.O.B.____________________

Insurance Company: ___________________________

Relationship to patient: _________________________

Deductible: ________________ Copay: _______________________

Policy I.D. #: _________________________________ Group/Plan #: ____________________________

Phone # of Insurance Company for Pre-Certification: ____

Assignment of Benefits:

I authorize payment of medical benefits to the named provider for professional services rendered.

Signature: ____ Date: ___________________________

Release for insurance and billing information:

Signature: ____ Date: ___________________________

Financial Responsibility:

I accept *FULL* financial responsibility for any and all charges incurred for services provided. This includes *FULL* responsibility for appointments missed OR cancelled within less than a 24-hour notice. This *ALSO* includes Concord Play Therapy the right to legally pursue *ANY & ALL* fees incurred for Non-payment, either through monthly late fees, (if applied), collection fees, and attorney fees. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure nothing has changed. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. In the event of default in payment, reasonable collection agency fees equal to (25%) shall be added to the amount on the account, plus any applicable court costs.

Signature: _______________________________________ Date: ____________________________