CLIENT INTAKE FORM

Please answer the questions to the best of your ability. It will help in the counseling process. All information is confidential..

Today's Date:_____ _____ _____

Note: If you have been a client here before, please fill in only the information that has changed.

A. DEMOGRAPHIC INFORMATION

LAST NAME:_____FIRST NAME:_____MIDDLE:_____

NICKNAME OR ALIASES: _____SOCIAL SECURITY #:_____-_____-_____DOB:___/___/_____

PREFERRED GENDER: MALE ☐ FEMALE ☐ NONBINARY ☐ GENDER QUEER ☐ OTHER ☐

RELATIONSHIP STATUS: SINGLE☐ MARRIED☐ PARTNER☐ DIVORCED☐ WIDOW☐ OTHER☐

HOME ADDRESS:_____APT.:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____

Calls or emails will be discreet, but please indicate any restrictions:_____

PATIENT EMPLOYER INFORMATION: EMPLOYED ☐ STUDENT ☐ OTHER ☐ _____

COMPANY/SCHOOL:_____OCCUPATION:_____

B. REFERRAL: WHO REFERRED YOU TO US? COURT ORDERED (PLEASE SEE "**N**")

NAME:_____

MAILING ADDRESS:_____

MAY WE HAVE YOUR PERMISSION TO THANK THIS PERSON FOR THE REFERRAL? YES___ NO___

C. RESPONSIBLE PARTY INFORMATION:

☐Same as above (SECTION A) OR

LAST NAME:_____FIRST NAME:_____MIDDLE:_____

NICKNAME OR ALIASES: _____SOCIAL SECURITY #:_____-_____-_____DOB:___/___/_____

PREFERRED GENDER: MALE ☐ FEMALE ☐ NONBINARY ☐ GENDER QUEER ☐ OTHER ☐

RELATIONSHIP STATUS: SINGLE☐ MARRIED☐ PARTNER☐ DIVORCED☐ WIDOW☐ OTHER☐

HOME ADDRESS:_____APT.:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____

EMPLOYER INFORMATION: EMPLOYED ☐ STUDENT ☐ OTHER ☐ _____

COMPANY/SCHOOL:_____OCCUPATION:_____

D. PRIMARY INSURANCE INFORMATION:

☐ I prefer to pay out of pocket and not submit services through my health insurance plan OR

INSURANCE CO:_____ INSURANCE ID # OF PATIENT:_____

INSURANCE PHONE: ( )_____-_____ COPAY AMOUNT:$_____

EMERGENCY CONTACT NAME:_____

EMERGENCY CONTACT PHONE NUMBER ( )_____-_____

In order to file your insurance for you, we require that you check EACH box and sign your signature below:

○ I authorize release of my information and claim submissions to all my insurance carriers.

○ I understand that I am responsible for my or dependents bill and it is my responsibility to confirm my coverage and benefits. For any reason the submitted claims are not paid within 45 days of the date of service, I will become responsible for the entire bill.

○ I authorize Tracy E. Hill, Ph.D. & Associates LLC to act as my agent in helping me obtain payment from my insurance carriers.

○ I hereby authorize payment directly to Tracy E. Hill, Ph.D. & Associates LLC, if any, otherwise payable to me for their services as described, realizing I am responsible to pay non-covered services.

Signature (electronic or wet):_____ Date:_____/_____/_____

E. YOUR MEDICAL CARE: FROM WHOM OR WHERE DO YOU GET YOUR MEDICAL CARE?

PRIMARY DOCTOR'S NAME:___PHONE #:_____

ADDRESS:_____

If you enter treatment with us for psychological concerns, may we coordinate your treatment of care with your PCP (Primary Care Physician)? YES___ NO___

WHAT PHYSICAL OR MEDICAL PROBLEMS DO YOU HAVE NOW OR HAVE YOU HAD IN THE PAST?_____

WHAT MEDICATION/DOSAGE ARE YOU ON, IF ANY?_____

IF YOU ARE ON MEDICATION, WHAT IS IT FOR?_____

DO YOU SMOKE CIGARETTES?_____AGE STARTED?_____HOW OFTEN?_____WHAT AMOUNT?_____

DO YOU CURRENTLY DRINK ALCOHOL___, USE MARIJUANA IN ANY FORM___, USE INHALANTS___, LSD___, CBD___, PRESCRIBED PILLS___, COCAINE___ OR OTHER_____?

F. MILITARY EXPERIENCE:

DATES: ___/___/_____THROUGH ___/___/_____

BRANCH OF SERVICE:_____TITLE OR DUTIES:_____

REASON FOR LEAVING:_____

G. FAMILY HISTORY:

RELATIVE	**NAME**	**CURRENT AGE** (OR AGE AT DEATH, I.E. 52 D)	**MAJOR ILLNESSES** (OR CAUSE OF DEATH)
FATHER			
MOTHER			
STEPPARENTS			
GRANDPARENTS			
BROTHERS			
SISTERS			

H. SIGNIFICANT RELATIONSHIPS:

	NAME OF PERSON	**YOUR AGE WHEN RELATIONSHIP STARTED**	**YOUR AGE WHEN RELATIONSHIP ENDED**	**REASONS FOR ENDING RELATIONSHIP**
FIRST RELATIONSHIP				
SECOND				
THIRD				
CURRENT				

I. CHILDREN: (INDICATE RELATIONSHIP OF CHILDREN: BIOLOGICAL CHILD **C,** OTHER MARRIAGE OR RELATIONSHIP **P**, STEP CHILD **S** OR OTHER (ADOPTED, FOSTER, ETC.) **O**, IN THE LAST COLUMN)

NAME	**AGE**	**SEX**	**SCHOOL**	**GRADE**	**PROBLEMS?**	**C, P, S, O**

J. EMERGENCY INFORMATION:

IF SOME KIND OF EMERGENCY ARISES AND WE CANNOT REACH YOU DIRECTLY, OR WE NEED TO REACH SOMEONE CLOSE TO YOU, WHOM SHOULD WE CALL?

NAME:_____PHONE:_____

ADDRESS:_____

K. RELIGIOUS AND OTHER PERSONAL IDENTIFICATION:

RELIGIOUS DENOMINATION/AFFILIATION:

PROTESTANT___ CATHOLIC___ JEWISH___ ISLAMIC___ BUDDHIST___ OTHER:_____

RELIGIOUS INVOLVEMENT: NONE___ SOME/IRREGULAR___ ACTIVE___

HOW IMPORTANT ARE SPIRITUAL CONCERNS OR RELIGIOUS BELIEFS IN YOUR LIFE AND/OR COUNSELING EXPERIENCE?_____

IS THERE ANOTHER WAY YOU IDENTIFY YOURSELF AND CONSIDER IMPORTANT (e.g. sexual orientation, culture, etc.) AND YOU WOULD LIKE US TO KNOW?:_____

LANGUAGE SPOKEN IN THE HOME?_____

L. GENERAL INFORMATION: (*PLEASE FEEL FREE TO USE THE BACK FOR ADDITIONAL SPACE.*)

ARE YOU HAVING CONCERNS WITH RELATIONSHIPS? IF YES, WHICH ONES (EXAMPLE: MARITAL, FAMILY, OTHER, ETC.)? _____

WHAT WORRIES OR UPSETS YOU? _____

WHAT MAKES YOU HAPPY?_____

WHY DO YOU THINK YOU ARE HERE? PLEASE TELL US IN YOUR OWN WORDS._____

_____

WHAT WOULD YOU LIKE TO SEE HAPPEN OR CHANGE BECAUSE OF THIS COUNSELING?_____

_____

WHAT ELSE IS IMPORTANT FOR US TO KNOW?_____

WHAT WOULD YOU LIKE US TO ASK YOU ABOUT?_____

M. PREVIOUS COUNSELING:

WITH WHOM?_____WHEN?_____
FOR WHAT?_____WHAT WORKED?_____
WHAT DIDN'T WORK?_____

N. HISTORY/PRESENCE OF MENTAL HEALTH ISSUES: *PLEASE CHECK ANY THAT APPLY:*

☐ HISTORY OR CURRENT THOUGHTS OF SUICIDAL, HOMICIDAL OR VIOLENT BEHAVIOR. Please specify:_____

☐ HISTORY OR CURRENT PSYCHIATRIC EPISODES, HOSPITALIZATIONS OR DRUG/ALCOHOL DEPENDENCE. Please specify:_____

☐ HISTORY OR CURRENT DIAGNOSIS OF ANY OF THE FOLLOWING: BORDERLINE PERSONALITY DISORDER, MAJOR DEPRESSIVE DISORDER, BIPOLAR DISORDER TYPE 1, MENTALLY ILL/CHEMICALLY ADDICTED (MICA) AND/OR SCHIZOPHRENIA. Please specify:_____

O. COURT ORDER:

IF YOU HAVE BEEN COURT ORDERED TO SEE US, PLEASE PROVIDE INFORMATION BELOW AND ATTACH YOUR COURT ORDER SO WE CAN BETTER SERVE YOU.

☐ Custody Case ☐ Mental Health Court ☐ Other Court Evaluation ☐ Other

THIS OFFICE DOES NOT PRACTICE DISCRIMINATION.

THANK YOU for your valuable time providing this information.
It will help us get right to work during your first session.