Service Intake Form

Please print this form, read the information thoroughly and respond to the following questions fully. Please bring the completed document to your first session.

Our fee for Individual, Couples, and Family Counseling services is $60.00 per 50-minute session. We currently accept cash, check, or money order for services, but we do not accept insurance or credit cards for payment. Our self-pay policy provides for lower service rates, treatment flexibility, and a heightened level of confidentiality. Payment is due at the start of the session. Sessions canceled less than 16 hours before the scheduled time will be billed at the full rate. When visiting our offices please leave the parking places directly in front of the entrance free for the podiatry patients. Please Initial _______

I have read the above statement, the HIPPA information, and the Consent to Treat information. I had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to receive therapeutic services from Dr. Brian Patterson. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Dr. Brian Patterson. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Patterson. Please Initial _______

How did you hear about Dr. Brian Patterson? ____

Individual making contact with the office:
1] Name: ____ Gender: ___________ Age: _____ DOB: ____________
Telephone ________________________________ E-mail ____
Address ____

Please Circle One: Single ~ Married ~ Divorced ~ Living Together ~ Widowed ~ Married but separated ~ Other: ___________________

Occupation: ____

Who are you seeking Counseling Service for? Self ~ Self & Spouse/Significant Other ~ Self & Adult Child
Other – Explain: ____

Describe thoroughly why counseling is being sought: ____
____
____
____
____
____
____
Significant Other - Name: _____________________________________ Gender: _____ Age: _____ DOB: ___________
Occupation: ____
Phone & E-mail: ____

IS A FAMILY MEMBER AT RISK FOR SUICIDE OR ANY OTHER FORM OF SELF-HARM? PLEASE DESCRIBE:
____
____
____

If anyone is at risk for immediate harm contact 911 or
Netcare Access [Crisis Hotline] at 614-276-2273 - www.netcareaccess.org

If Individual therapy is being sought, please complete the following sections of the form. If marital/relationship counseling is being sought, each person please sign here and do not complete the remaining sections of this document.

Signed: ____ Date: _________

Signed: ____ Date: _________

Service Intake Form

Counseling or Substance Abuse Treatment History			
☐ None			
	Reported Agency/ Counselor Names	Dates of Service	Reason for Treatment
1			
2			
3			
4			
5			

Mental Health Medication			
☐ None			
	Medication	Dates of Use	Reason for Medication
1			
2			
3			
4			
5			

Any Additional Pertinent Information: ____
____
____
____

Family History of Mental Health Issues and/or Substance Abuse	
Mother's Family:	

Drug/Alcohol History:
____
____
____
____
____

Mental Health Issues History:
____
____
____
____
____

Father's Family:	

Drug/Alcohol History:
____
____
____
____
____

Mental Health Issues History:
____
____
____
____
____

Service Intake Form

Abuse History

☐ No History of Abuse/Violence
☐ Physical Abuse
☐ Domestic Violence/Abuse
☐ Emotional Abuse
☐ Physical Neglect
☐ Sexual Abuse/Molestation
☐ Community Violence
☐ Community Violence
☐ Elder Abuse
☐ Self-harm Comments: ____
____
____

Legal History: ☐ None Reported or Describe History
____
____
____

	Drug and Alcohol use History				
	Name of Substance	Age 1st Used	Date Last Used	Typical Frequency of Use in last 12 months	Typical Amount Used in last 12 months
1					
2					
3					
4					
5					
6					
7					

Behavioral Addictions – Please check the item(s) that applies

☐ Pornographic Material
☐ Sex
☐ Disordered Eating
☐ Television
☐ Internet
☐ Gambling
☐ Technology
☐ Shopping
☐ Hoarding
☐ Video Games
☐ Cutting
☐ Stealing
☐ Other: ____

1. Nutritional/Eating Pattern Changes/Disorders ______________________________
____
____

2. Depressed Mood/Sad ____
____
____
____

Service Intake Form

3. Bereavement Issues ____
____
____

4. Anxiety ____
____
____

5. Traumatic Stress ____
____
____

6. Anger/Aggression ____
____
____

7. Oppositional Behaviors ____
____
____

8. Inattention ____
____
____

9. Impulsivity ____
____
____

10. Mood Swings/Hyperactivity ____
____
____

11. Sleep Problems ____
____
____

12. Other ____

Any Additional Relevant Information: ____
____
____
____
____
____
____
____
____
____
____
____
____

Signed: ____ Date: __________