SERVICE INTAKE FORM

Dr. L. Brian Patterson LPCC-S, LICDC-CS, CISM ~ 614-832-3355 * DocBrian.com

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

Record Keeping Options

In accordance with HIPPA privacy laws, I ***opt out*** of having notes taken of our conversations.

_____
Signature

_____
Date

OR

In accordance with HIPPA privacy laws, I ***opt to*** have notes taken of our conversations.

_____
Signature

_____
Date

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? _____

Client One] 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: _____

Client Two] Name: _____ Gender: _____ Age: _____ DOB: _____
Telephone _____ E-mail _____
Address _____
Please Circle One: Single ~ Married ~ Divorced ~ Living Together ~ Widowed ~ Married but separated ~ Other: _____
Occupation: _____

Describe thoroughly why counseling is being sought: _____
_____
_____
_____
_____
_____
_____
_____
_____

Counseling or Substance Abuse Treatment History
Please describe previous mental health services received

CLIENT ONE		CLIENT TWO
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
☐ None		☐ None

Mental Health Medications
Please describe previous mental health medications received

CLIENT ONE		CLIENT TWO
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
☐ None		☐ None

Mental Health Concerns

CLIENT ONE		CLIENT TWO
Behavioral Addictions ☐ Pornographic Material ☐ Sex Disordered Eating ☐ Disordered Eating ☐ Television ☐ Internet ☐ Gambling ☐ Technology ☐ Shopping ☐ Hoarding ☐ Video Games ☐ Cutting ☐ Stealing ☐ Other:	**Abuse History** ☐ No History of Abuse/Violence ☐ Physical Abuse ☐ Domestic Violence/Abuse ☐ Emotional Abuse ☐ Physical Neglect ☐ Sexual Abuse/Molestation ☐ Community Violence ☐ Elder Abuse ☐ Self-harm ☐ Other Comments:	**Behavioral Addictions** ☐ Pornographic Material ☐ Sex Disordered Eating ☐ Disordered Eating ☐ Television ☐ Internet ☐ Gambling ☐ Technology ☐ Shopping ☐ Hoarding ☐ Video Games ☐ Cutting ☐ Stealing ☐ Other:	**Abuse History** ☐ No History of Abuse/Violence ☐ Physical Abuse ☐ Domestic Violence/Abuse ☐ Emotional Abuse ☐ Physical Neglect ☐ Sexual Abuse/Molestation ☐ Community Violence ☐ Elder Abuse ☐ Self-harm ☐ Other Comments:

Mental Health Concerns

CLIENT ONE		CLIENT TWO
Current Concerns ☐ Depressed Mood/Sad ☐ Bereavement Issues ☐ Anxiety ☐ Traumatic Stress ☐ Anger/Aggression ☐ Oppositional Behaviors ☐ Inattention ☐ Impulsivity ☐ Mood Swings/Hyperactivity ☐ Sleep Problems ☐ Other _____	**Subtance Abuse History** ☐ Alcohol ☐ Marijuana ☐ Cocaine (Powder/Crack) ☐ Opioids – (Pills/Heroin/Fentanyl) ☐ Rx Pills: _____ ☐ PCP Phencyclidine ☐ Crystal Meth ☐ Hallucinogens ☐ MDMA (Ecstasy/Molly) ☐ Kratom ☐ DMT ☐ Sizzurp (codeine & promethazine) ☐ Khat ☐ Salvia ☐ Tobacco ☐ Other _____	**Current Concerns** ☐ Depressed Mood/Sad ☐ Bereavement Issues ☐ Anxiety ☐ Traumatic Stress ☐ Anger/Aggression ☐ Oppositional Behaviors ☐ Inattention ☐ Impulsivity ☐ Mood Swings/Hyperactivity ☐ Sleep Problems ☐ Other _____	**Subtance Abuse History** ☐ Alcohol ☐ Marijuana ☐ Cocaine (Powder/Crack) ☐ Opioids – (Pills/Heroin/Fentanyl) ☐ Rx Pills: _____ ☐ PCP Phencyclidine ☐ Crystal Meth ☐ Hallucinogens ☐ MDMA (Ecstasy/Molly) ☐ Kratom ☐ DMT ☐ Sizzurp (codeine & promethazine) ☐ Khat ☐ Salvia ☐ Tobacco ☐ Other _____

_____ _____ _____ _____
Client One Signature Date Client Two Signature Date