

Adult Intake Form



**PUSHING
BOUNDARIES**
MENTAL HEALTH

General Information

Name

Date of Birth

Age

Address

City

State

Zip Code

Phone #

Email

Is it ok to leave messages at this phone number? Yes No May we contact you via email? Yes No

Would you like to be added to our email list? Yes No

Emergency Contact Name

Phone #

Race: White Black/African American Asian Latinx/Hispanic Native American Multi-racial

Birth sex: Female Male Intersex Prefer not to disclose

Gender: Female Male Non-binary Transgender Prefer not to disclose

Preferred pronouns

Spirituality

Insurance Information

Primary Insurance

Phone Number

Insured Name

DOB

SSN #

Member Number

Group Number

Employer Name

Family Information

Marital Status: Single Married Partnered Widowed Divorced Separated _____

Spouse/Partner

Age

Lives with you? Y N

How satisfied are you with your relationship? Very Satisfied Satisfied Neutral Unsatisfied Very Unsatisfied

Do you have children? Yes No If no, please skip to the next section.

Child

Age

Lives with you? Y N

Child

Age

Lives with you? Y N

Child

Age

Lives with you? Y N

Child

Age

Lives with you? Y N



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Family History

Who were you raised by?

How many siblings do you have?

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and respective relationships with your siblings:

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

Support System

Do you have a support system? Yes No

Please explain:

What is your current living situation?

Is your home environment safe? Yes No

If no, please explain why:

Employment/Education Status

Employer/School

Occupation/Years in School

Please check all that apply:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Employed Part Time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed Full Time | <input type="checkbox"/> Retired | <input type="checkbox"/> Student |

What is your highest level of education completed?

- | | | |
|--|--|---|
| <input type="checkbox"/> Less Than High School | <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> High School/GED | <input type="checkbox"/> Some College | <input type="checkbox"/> Post Graduate Degree |



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Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Anger/Rage | <input type="checkbox"/> Obsessive/Intrusive Thoughts | <input type="checkbox"/> Self Injury |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Death in Family | <input type="checkbox"/> Panic/Phobia | <input type="checkbox"/> Thoughts of Harming Others |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Paranoia/Delusions | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Poor Sleep Patterns | <input type="checkbox"/> Weight Gain/Loss |

Have you experienced abuse? Yes No

If yes, please explain:

Have you ever been admitted to the hospital for mental health reasons? Yes No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? Yes No

If yes, please explain:

Have you had therapy in the past? Yes No If yes, was it helpful? Yes No

Previous therapist

Dates seen

Medical History

Are you currently taking any medications? Yes No

If yes, please list:

Have you had any surgeries or operations? Yes No

If yes, please list:

Do you currently have any medical problems? Yes No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? Yes No

Physician

Phone Number

Permission to contact physician? Yes No



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Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Divorce | <input type="checkbox"/> Physical/Sexual Abuse |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Financial Crisis/Unemployment | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Death | <input type="checkbox"/> Frequent Relocations | <input type="checkbox"/> Serious illness |
| <input type="checkbox"/> Debilitating Injuries/Disabilities | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Other _____ |

Personal History

What symptoms are you dealing with? Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Appetite Problems | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> OCD Symptoms |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Low Interest/Motivation | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Energy Levels | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Thoughts of Self-harm/Suicide |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Trouble Sleeping |
| | | <input type="checkbox"/> Other _____ |

How long have you been dealing with these?

What effect do these have on your life? Minimal Mild Moderate Severe

Habits & Lifestyle

Do you regularly drink alcohol? Yes No

If yes, how often:

Are you dealing with any addictions? Yes No

If yes, please explain:

How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily

Do you consider your alcohol/drug use a problem? Yes No Unsure

Do you exercise regularly? Yes No

If yes, please describe what you do and how often:

Do you have hobbies? Yes No

If yes, what are they and how often do you do them?

What do you do for fun?



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Legal Summary

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Custody/Divorce | <input type="checkbox"/> Fraud | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Driving Offenses | <input type="checkbox"/> Immigration | <input type="checkbox"/> Violence |

Have you ever been imprisoned? Yes No

If yes, please explain:

Are you court ordered for services? Yes No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? Yes No

If yes, please list them here: Name: _____ Phone Number: _____

Will you require progress reports for legal authorities? Yes No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?

Payment Information & Authorization



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Scheduling Information

Please check all the appointment days and times that are ideal for you:

- | | | | | | |
|------------------------------------|-----------------------------|-----------------------------|-----------------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> Monday | <input type="checkbox"/> AM | <input type="checkbox"/> PM | <input type="checkbox"/> Thursday | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> AM | <input type="checkbox"/> PM | <input type="checkbox"/> Friday | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> AM | <input type="checkbox"/> PM | <input type="checkbox"/> Weekend | <input type="checkbox"/> AM | <input type="checkbox"/> PM |

Payment Information

Amount

- Cash Check Credit Card

Credit Card Authorization

Please complete all of the fields below if you plan on paying by credit card. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Name on Card

Zip Code

Credit Card Number

Card Expiration

Card Type Visa Mastercard AMEX Discover Other

By signing below, I authorize BUSINESS NAME to charge the credit card above for agreed-upon purchases and fees. I understand that my information will be saved for future transactions on my account.

Name Printed

Signature

Date

Cancellation & No Show Policy



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Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 48 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone at 865-738-7901.

ALL NO-SHOWS AND ANY APPOINTMENTS CANCELLED, RESCHEDULED, OR CHANGED WITHOUT 48 HOURS' NOTICE WILL BE BILLED TO YOUR ACCOUNT IN THE AMOUNT WE WOULD HAVE COLLECTED IF THE SERVICE HAD BEEN PROVIDED AS SCHEDULED.

Please keep in mind that insurance does not reimburse for missed appointments; therefore, you will be responsible for the full payment of the appointment fee. For example, if a therapy session is \$100, and you have a \$35 copay you would be responsible to pay \$100 for a late cancellation or missed appointment.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

ARRIVAL TIME

Please arrive at your appointment at least 5 minutes prior to your scheduled appointment time. All therapy has a specific time schedule. An early arrival allows for a relaxed experience. If you arrive late, your therapy may be shortened in order to maintain our schedule.

LATE ARRIVAL POLICY

All appointments begin and end on time in order to maintain our schedule. If the therapy does not start on time due to client tardiness, the therapy time will be reduced accordingly and you will still be required to pay full price. If a client is more than 15 minutes late, the appointment will be considered a cancellation.

I have read and understood the cancellation and refund policy and agree to abide by the above conditions.

Name Printed

Signature

Date

Informed Consent for Counseling and Psychotherapy



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This informed consent document is intended to provide general information about the counseling services provided by Chapter & Page Counseling LLC. This is a legal document; please read it carefully before signing.

Mental Health Services

Chapter & Page Counseling LLC recognizes that it may not be easy to seek help from a mental health professional. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Nature of Therapy & Risks

It is important to understand that there are both benefits and risks associated with participation in therapy. Therapy may improve the ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. However, clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. Therapy can lead to unanticipated feelings and change, which might have an unexpected impact on you, and your relationships. For example, marital therapy may lead to the possibility of exercising the divorce option.

Relationship

The relationship you have with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. It is not appropriate to share gifts, barter, or trade services with your therapist.

Confidentiality

Discussions between you and your therapist are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist when you and the therapist discuss this matter further.

After-Hour Concerns & Emergencies

As a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, you may contact your therapist in between sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Communication

By signing the Informed Consent for Counseling and Psychotherapy document, you are consenting for Chapter & Page Counseling LLC to communicate with you by phone, e-mail, and at the address provided on your client intake form. You agree to notify us if you need to opt out of any form of communication.



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Fees

- The fee for individual therapy sessions are \$75 per session and are approximately 45 minutes in length.
- The fee for conjoint (marital /family) therapy sessions are \$75 per session and approximately 50 minutes in length.
- The fee for group therapy sessions are \$50 per session and approximately 50 minutes in length.
- Fees are payable at the time that services are rendered.
- If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Insurance

Please talk to your therapist if you plan to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Ultimately, the financial responsibility is yours and you will be required to pay for services in the event that your insurance does not cover them. Please discuss any questions or concerns that you may have about this with your therapist.

Notice to Clients

The AZ board of behavioral health examiners receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at <https://www.azbbhe.us>, or by calling 602-542-1882.

Consent to Treat

By signing the Informed Consent for Counseling and Psychotherapy, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services and that you may stop such care, treatment, or services at any time. By signing the Informed Consent for Counseling and Psychotherapy document you acknowledge that you have both read and understood all the terms and information contained herein. You also agree that you have had the opportunity to ask questions and seek clarification of anything that remains unclear and that those questions have been answered satisfactorily.

Your signature below indicates that you have read this agreement for services carefully and understand its contents.

Name Printed

Signature

Date