



West Des Moines
**CENTER FOR
PSYCHOTHERAPY**

ADULT INTAKE FORM

FOR OFFICE USE ONLY

Client File No:	Today's Date:
Payment Method:	
Closing Date:	

DEMOGRAPHIC INFORMATION

First Name:	Middle:	Last Name:	
Nickname:		Date of Birth [mm/dd/yyyy]:	Age:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity:		
Relationship Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Cohabiting <input type="checkbox"/> Widowed	<input type="checkbox"/> Dating <input type="checkbox"/> Other: _____
Employer:	<input type="checkbox"/> Currently Unemployed	Occupation:	
Level of Education:		Degree:	
Home Address:		City:	Zip:
Mobile Phone: _____ Can we call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone: _____ Can we call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone: _____ Can we call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Which phone number do you prefer that we use to contact you?		<input type="checkbox"/> Mobile	<input type="checkbox"/> Home <input type="checkbox"/> Work
E-Mail: _____ Can we e-mail you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want us to e-mail you appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please note that email is <u>not</u> a secure form of communication and therefore your privacy and confidentiality cannot be guaranteed. If you would like us to send you appointment reminders, you understand that you are authorizing us to contact you via e-mail.		

EMERGENCY CONTACT INFORMATION

Please be sure to provide as much information below so I can easily reach your emergency contact. Providing this information does not constitute a release of information. If you would like this person to have access to your records, you will need to give us permission to do so. This person will only be contacted under instances specified in your HIPAA Agreement.

First Name:	Middle:	Last Name:	
Address:			City:
State:	Zip:	Relationship:	
Mobile Phone:	Home Phone:	Work Phone:	

PRESENTING CONCERNS

Please list the reason(s) for which you are seeking counseling at this time.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL INFORMATION

Primary Care Physician (PCP):	
Name:	Organization:
Would you like me to communicate with your PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please ask for a release of information.	
Psychological History	
Have you received previous counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who was your provider?
Psychiatric History	
Have you received or are you currently receiving psychiatric help? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Current	
Psychiatrist:	Organization:
Diagnosis:	
Have you ever been hospitalized as a result of this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ [mm/dd/yyyy]	
Has your psychiatrist prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like me to communicate with your psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please ask for a release of information.	
Health History	
Do you have any serious medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe: _____	
Are you currently taking any medications not prescribed by a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe: _____	
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe: _____	

SUBSTANCE USE INFORMATION

Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many days per week?	How many times per day?
Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many days per week?	How many cigarettes per day?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sporadically	If yes, which days of the week? <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su	
How many drinks do you have per day? <input type="checkbox"/> 1 - 3 <input type="checkbox"/> 4 - 6 <input type="checkbox"/> 7 - 9 <input type="checkbox"/> 10 - 12 <input type="checkbox"/> 13+		
Would you describe yourself as being a(n): <input type="checkbox"/> Social Drinker <input type="checkbox"/> Binge Drinker <input type="checkbox"/> Problematic Drinker <input type="checkbox"/> Alcoholic		
Do you use illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many days per week?	How many times per day?
Would you describe yourself as being a(n): <input type="checkbox"/> Recreational User <input type="checkbox"/> Problem User <input type="checkbox"/> Addict		

REFERRAL INFORMATION

Were you referred to us? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who referred you?	
If no, how did you hear about us?		
<input type="checkbox"/> Website	<input type="checkbox"/> Psychology Today	<input type="checkbox"/> Medical Doctor
<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other: _____

PAYMENT INFORMATION

Will you be paying out-of-pocket for the services received at the West Des Moines Center for Psychotherapy?

Yes No

Your signature below represents your acknowledgement and understanding that: 1) you will be personally responsible for all charges involved in the rendering of our services; 2) payment will be due at the time of each visit unless you have made other arrangements in advance; and, 3) a service fee of \$100 will be charged for appointments that are not attended or cancelled without sufficient notice (we request an advanced notice of at least 48 hours) as we reserve that time to work with you.

Client Signature

Will you be paying for services incurred at our office with your insurance or workman's compensation?

Yes No

While your insurance or another person may be paying for all or part of our charges, our agreement is with you. Your signature below indicates your understanding and acknowledgement that: 1) you will be personally responsible for all charges involved in the rendering of our services not paid by your insurance company; 2) payment will be due at the time of each visit unless you have made other arrangements in advance; and 3) a service fee of \$100 will be charged for appointments that are not attended or cancelled without sufficient notice (we request an advanced notice of at least 48 hours) as we reserve that time to work with you. We will be filing your insurance claim for you; however, we suggest that you call your insurance company to get information regarding your co-payment and/or deductible before your first session. Ask them about your coverage for "outpatient mental health services" so you may determine the appropriate payment for our services.

Client Signature

PRIMARY INSURANCE COMPANY:

Company Name: _____

Subscriber Name: _____

Subscriber Date of Birth [mm/dd/yyyy]: _____

Subscriber SSN: _____

Subscriber #: _____ Group #: _____

Co-Payment Amount: _____

*** A COPY OF YOUR INSURANCE CARD IS REQUIRED.

SECONDARY INSURANCE COMPANY (IF APPLICABLE):

Company Name: _____

Subscriber Name: _____

Subscriber Date of Birth [mm/dd/yyyy]: _____

Subscriber SSN: _____

Subscriber #: _____ Group #: _____

Co-Payment Amount: _____

*** A COPY OF YOUR INSURANCE CARD IS REQUIRED.

INSURANCE PAYMENT AUTHORIZATION:

I hereby authorize insurance payment directly to my psychology provider not to exceed the balance due for regular charges. I understand that I am financially responsible to my provider for charges not covered by insurance. A photocopy of this document shall be valid as the original.

Signature of Client: _____

Date [mm/dd/yyyy]: _____

INSURANCE RELEASE OF INFORMATION AUTHORIZATION:

I hereby authorize my psychologist to release my mental health records to my insurance company to the full extent specified under any or all federal laws and Iowa Code Chapter 228, or as subsequently amended, for the purpose of payment submission; administration of claims; to conduct utilization and quality control review; or to conduct audit of claims paid.

I am aware that I may inspect the information disclosed and may revoke this authorization at any time if I furnish written revocation to my mental health provider; thus, I agree to accept financial liability for services provided if insurance should deny claims for benefits because of the inability to examine my mental health records. A photocopy of this authorization will be valid as the original.

Signature of Client: _____

Date [mm/dd/yyyy]: _____