West Des Moines
CENTER FOR PSYCHOTHERAPY

ADULT INTAKE FORM

FOR OFFICE USE ONLY	
Client File No:	Today's Date:
Payment Method:	

DEMOGRAPHIC INFORMATION

First Name:	Middle:	Last Name:
Preferred Name:	Date of Birth [mm/dd/yyyy]:	Age:
Preferred Pronouns:	Race:	Ethnicity:
Gender Identity:	Sexual Orientation:	
Relationship Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed ☐ Dating ☐ Other: _____		
Employer: ☐ Currently Unemployed	Occupation:	
Level of Education:	Degree:	
Home Address:	City:	Zip:

Mobile Phone: _____ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Home Phone: _____ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No	Work Phone: _____ Can we call this number? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No

Which phone number do you prefer that we use to contact you? ☐ Mobile ☐ Home ☐ Work

E-Mail: _____
Can we e-mail you at this address? ☐ Yes ☐ No
Do you want us to e-mail you appointment reminders? ☐ Yes ☐ 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 a <u>local</u> contact and as much information below so we 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 by HIPAA.

First Name:	Middle:	Last Name:
Address:	City:	Zip:
Home Phone:	Cell Phone:	Work Phone:
What is your relationship to this individual?		

PRESENTING CONCERNS

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

_____

_____

_____

_____

MEDICAL INFORMATION

Primary Care Physician (PCP):	
Name:	Clinic:
Would you like me to communicate with your PCP? ☐ Yes ☐ No If yes, please ask for a release of information.	
Psychological History	
Have you received previous counseling? ☐ Yes ☐ No	If yes, who was your provider?
Provider's Phone:	Diagnosis:
Did you find counseling beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial	
Psychiatric History	
Have you received psychiatric help? ☐ Yes ☐ No ☐ Current	Psychiatrist's Name:
Psychiatrist's Phone:	Diagnosis:
Have you ever been hospitalized as a result of this diagnosis? ☐ Yes ☐ No If yes, when? _____ [mm/dd/yyyy]	
Has your psychiatrist prescribed medication? ☐ Yes ☐ No	Are you currently taking this medication? ☐ Yes ☐ No
Would you like me to communicate with your psychiatrist? ☐ Yes ☐ No If yes, please ask for a release of information.	
Did you find your psychiatric care beneficial? ☐ Very Beneficial ☐ Beneficial ☐ Somewhat Beneficial ☐ Not Beneficial	
Health History	
How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
Do you have any serious medical conditions? ☐ Yes ☐ No If yes, please describe: _____	
Are you currently taking any medications not prescribed by a psychiatrist? ☐ Yes ☐ No (Please list all medications you are currently taking in the separate medication form.)	
Have you ever been hospitalized for a mental health condition? ☐ Yes ☐ No If yes, please describe: _____	

SUBSTANCE USE INFORMATION

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

REFERRAL INFORMATION

Were you referred to us? ☐ Yes ☐ No	If yes, who referred you?

If no, how did you hear about us?

☐ Website ☐ Psychology Today ☐ Medical Doctor
☐ Insurance Company ☐ Yellow Pages ☐ 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 to get information regarding your coverage before your first session.

_____
Client Signature

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.

Client Signature: _____ 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.

Client Signature: _____ Date [mm/dd/yyyy]: _____