A Journey To Peace LLC

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Clinical Therapy Intake Form

Patient Demographic Information

Name:_____ Date:_____
Last First

Date of Birth:_____ Age:_____ Gender:_____
Marital Status:_____ Sexual orientation:_____
Ethnicity/Race:_____
Do you have children (if so, please provide gender and ages):_____
Religion/denomination:_____

Address:_____
Street City State Zip Code

Phone Number:_____ May we leave a message?_____
Can we send a text message?_____
Email Address:_____ May we leave a message? _____

Emergency Contact Person:_____ Phone Number:_____

Current Employer:_____
Job Title/Position:_____
Highest level of education completed:_____
Military History:_____
Criminal History:_____

Health Insurance Information:

Name of Health Insurance Company:_____
Phone Number:_____
Policy Number:_____ Group Number:_____

Medical History

Primary Care Physician:_____ Phone Number:_____

Medical Diagnosis:_____
_____

Current Medications (with dosages, please include vitamins or supplements):_____
_____

Have you ever been hospitalized?:_____ If so, for what? (please include approximate dates):_____
_____

Mental Health History

Have you ever been in therapy before? (if so, when and for how long):_____
_____
Have you ever seen a psychiatrist? (if still seeing, please provide contact information):_____
_____

Mental Health Diagnosis: _____
_____

History of Psychiatric Hospitalizations (please include approximate dates and reason):
_____
_____

Have you ever had any thoughts of harming or cutting yourself? (if so, when):_____
_____

Have you ever attempted suicide or harmed yourself? (if so, when):_____
_____

Do you currently have thoughts of harming yourself now?:_____

Have you experienced trauma? (for example, physical, sexual or emotional abuse or violent crime:_____

Do you have any family members with mental health issues? (if so, please list relational status and diagnosis, if known):_____
_____

Substance Abuse History

Do you drink alcohol? (if so, how often):_____
Do you smoke cigarettes? (if so, how often):_____
Do you smoke marijuana? (if so, how often):_____
Do you use any other substances not listed above? (if so, please list them and state how often):
_____
_____

Have you ever been in an outpatient, inpatient or residential substance abuse program? (if so, when):_____
_____

Do you have any family members with substance abuse problems? (if so, please list relational status and substance):_____

Current Situation:

Why are you seeking therapy at this time?_____
_____

What would you like to accomplish from therapy?_____
_____

How did you hear about us?_____

Client Agreements

I understand whatever I discuss in session is confidential and will not be disclosed to anyone unless I give written consent in the form of a completed release of information form, or am at risk for harm to myself or others or violate any of the information discussed in the HIPAA Confidentiality that I have signed.

I understand that if I am 15 minutes or more late to my appointment, I will be rescheduled for the next available appointment.

I understand that if I do not provide at least 24 hours' notice for a cancelled appointment (except in the case of serious emergencies), I will be charged $50.00 for each missed appointment. This fee must be paid before another appointment can be scheduled. The cancellation fee cannot be paid by my insurance company or EAP.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If authorization is not obtained, you will be responsible for full payment of services. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by cash or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before insurance companies are willing to begin paying any amount for services. It is important to remember you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract. The therapy fee is $150.00 per hour which has been explained in the client fee schedule which I have signed. I agree to pay this amount or to have the therapy fee billed to my insurance company (if I agreed to go through my insurance company for therapy or using EAP benefits).

I agree that all of the information provided in this form is accurate to the best of my knowledge

Client Name (printed):_____
Client Signature:_____ Date:_____

Therapist Signature:_____ Date:_____