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:__________________