Psychiatric Intake Form

(All information on this form is strictly confidential)
Please complete all information on this form, print and bring with you to your first appointment with Owens & Associates Counseling & Therapy, LLC.

Name: _____Date:_____

*Name you prefer to be called by*_____*Pronouns*_____

Date of Birth _____Social Security Number _____

Address _____

Cell Phone _____ Email _____

Emergency Contact Person _____Phone _____

Responsible Party:

Name _____ Relationship _____

Address _____

SSN# _____ DOB _____Phone _____

Referred by:

Name _____ Phone _____

Address _____

Primary Care Physician _____

Current Psychiatrist _____ Psychiatrist's Phone _____

What are the problem(s) you are seeking help for?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

_____

Insurance Information:

Name of Company: _____ ID #_____

Group #: _____Authorization#_____

Current Symptoms Checklist: (check all that apply)

Depressed mood ☐	Racing thoughts ☐	Excessive worry ☐
Unable to enjoy activities ☐	Impulsivity ☐	Anxiety attacks ☐
Loss of interest ☐	Increased libido ☐	Hallucinations ☐
Concentration/forgetfulness ☐	Decrease need for sleep ☐	Suspiciousness ☐
Change in appetite ☐	Increase need for sleep ☐	Excessive guilt ☐
Fatigue ☐	Excessive energy ☐	Increased irritability ☐
Decreased Libido/sex drive ☐	Crying spells ☐	Other _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes ☐ No ☐

If Yes, please answer the following. If No, please skip to Past Psychiatric History.

Do you currently feel that you don't want to live? Yes ☐ No ☐

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Homicide Risk Assessment

Have you ever had feeling or thoughts of harming another? _____

If Yes, please answer the following. If No, please skip to Past Psychiatric History.

Do your currently feel that you want to hurt someone? Yes ☐ No ☐

How often do you have these thoughts? _____

When was the last time you had thoughts of hurting someone? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to hurt someone else currently? _____

Your Medical History:

Allergies _____ Current Weight_____Height _____

List all current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

Current over-the-counter medications or supplements: _____

_____

Past Psychiatric History

Outpatient treatment Yes ☐ No ☐ If yes please describe for what reason, when and where.

Reason Date Treated By Whom

_____

_____

_____

Psychiatric Hospitalization Yes ☐ No ☐ if yes please describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: if you have ever taken any psychiatric medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

_____

_____

_____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Suicide ☐ Yes ☐ No
Violence ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No
Post-traumatic stress ☐ Yes ☐ No
Alcohol abuse ☐ Yes ☐ No
Other Substance abuse ☐ Yes ☐ No

If yes, who had what problems_____

Has any family member been treated with a psychiatric medication? Yes ☐ No ☐
if yes, who was treated and what medications and how effective was the treatment?

_____

_____

_____

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances? _____
If yes, where were you treated and when? _____
Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which ones? _____
Have you abused prescription medication? ☐ Yes ☐ No
If yes, which ones? _____

Family Background and Childhood History

Were you ever adopted? ☐ Yes ☐ No
Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Are your parents divorced? ☐ Yes ☐ No If so, how old were you at the time? _____
If your parents are divorced, who did/do you live with? _____
Describe your father and your relationship with him _____
_____
Describe your mother and your relationship with her _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and When? _____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No
Please describe when, where and by whom? _____
_____

Educational History

Did you attend college? ____ Where? ____ Major? _____
What is your highest educational level or degree attained? _____
Current School
Attendance: ☐ Daily ☐ Regularly ☐ Intermittent ☐ Refuse/Reason _____

Occupational History

Are you currently ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____ What is /was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so what branch? _____
Honorable discharge? ☐ Yes ☐ No other type of discharge? _____

Relationship History and Current Family

Are you currently? ☐ Married ☐ Divorced ☐ Single ☐ Widowed
How long? _____
If not married, are you currently in a relationship? ☐ Yes ☐ No
What is your spouse/partner/significant other's occupation _____
Describe your relationship with your spouse/partner/significant other: _____
Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____
How long? _____
Do you have children? ☐ Yes ☐ No If yes, list ages and gender? _____
Describe your relationship with you children: _____
List everyone who currently lives with you: _____

Legal

Have you ever been arrested? _____ Do You have any pending legal problems? _____

Consent for Treatment

I hereby authorize Owens & Associates Counseling & Therapy, LLC. to render mental health services to me. I have read and understand these policies and have received a copy for myself.

Signature:_____ Printed Name: _____ Date: _____

Responsible Party for minors under the age of 13:

Signature:_____ Date:_____

Name:_____ Relationship: _____

HIPAA

I acknowledge that I have viewed/have been offered a copy of the Notice of Privacy Practices explaining HIPAA. This is also available on our website, owenscounseling.com

Signature:_____ Date:_____

Name:_____ Relationship: _____

Financial Responsibility:

I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance carrier. Including; **copays, coinsurance, deductibles and insurance plan refusal to pay for failure to obtain authorization. Any missed and late cancellations will be charged to the card obtained on file of $110.00. Case management (Which includes court letters, phone conversations with school representative, GAL meetings, letters, anything outside of the regular session with client.) Case management cost are billed in minutes (1-20 minutes=$60.00, 21-30 minutes=$90.00, 31-50 minutes=$110.00, 51-60minutes=$150.00).**

If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature:_____ Date: _____

Signature of Responsible Party:_____ Date: _____

Are you signing this form electronically? Yes ☐ No ☐

MUST BE COMPLETED AT THE TIME OF INTAKE

Please provide the following credit card information. It is understood that despite your means of payment you authorize Owens & Associates Counseling & Therapy Center, LLC., to use the provided credit card as explained below.

THIS INFORMATION MUST BE COMPLETED. ALL INFORMATION IS KEPT CONFIDENTIAL AND WILL BE USED FOR ANY COPAY, CO-INSURANCE, DEDUCTIBLE, NO SHOW/LATE CANCELLATION FEES OR TO CLEAR UP ANY OUTSTANDING BALANCE

Account Number _____ Expiration Date _____

V-Code (3 digits) _____ Name as it appears in card _____

Please Select the following: **Visa**☐ **MasterCard**☐ **Discover**☐

Owens and Associates does NOT accept American Express

Signature _____

Email Address: _____