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 _________________

How do you want to receive your appointment reminder? Phone call____ Email____ Text Message____ All___ None___

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).

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___

___

Family Psychiatric History

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

Bipolar disorder	Yes	No	Schizophrenia	Yes	No
Depression	Yes	No	Post-traumatic stress	Yes	No
Anxiety	Yes	No	Alcohol abuse	Yes	No
Suicide	Yes	No	Other Substance abuse	Yes	No
Violence	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 (5-10 minutes=$30.00, 11- 20 minutes=$60.00, 21-30 minutes=$90.00, 31-50 minutes=$110.00, 51-60 minutes= $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: _____________________________________