Preston Counseling, PLLC
INDIVIDUAL INTAKE

CLIENT'S FULL NAME: ______________________________TODAY'S DATE: ____________

ADDRESS: ____
STREET OR P.O. BOX

____
CITY STATE ZIP

TELEPHONE: HOME ______________CELL________________WORK ________________

AGE: ________BIRTHDATE: ____________SSN#: ______________________________

MARITAL STATUS: ________________ DRIVER'S LICENSE#:_______________________

EMPLOYER OR SCHOOL (IF STUDENT): ____

REFERRED BY: ____________________________PHONE:___________________________

PERSON TO CONTACT IN AN EMERGENCY:

____
NAME RELATIONSHIP PHONE

INSURANCE INFORMATION

INSURANCE COMPANY: ____________________NAME OF INSURED:____________________

INSURED'S SSN#: ________________________INSURED'S D.O. B.: __________________

INSURED'S POLICY #:______________________INSURED'S GROUP #: ________________

INSURED'S EMPLOYER: ______________________________AMOUNT OF CO PAYS: ________

AMOUNT OF DEDUCTIBLE __________ ANNUAL DEDUCTIBLE MET? YES______ NO_______

ANNUAL VISIT MAXIMUM ? YES_________ NO_________ # OF VISITS?____________

INSURED'S RELATIONSHIP TO CLIENT:_______________________________________

AUTHORIZATION #:____

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, PLEASE LIST AUTHORIZATION NUMBER AND HOW MANY SESSIONS ARE BEING AUTHORIZED.

EAP COMPANY AUTHORIZATION NUMBER # OF SESSIONS

____

To be completed by therapist:

Primary diagnosis____________ **Secondary diagnosis**__________

TREATMENT AGREEMENT:

PLEASE INITIAL:_______________

CO-PAYMENTS AND DEDUCTIBLE ARE DUE AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR VERIFYING CO-PAYMENT, DEDUCTIBLE AND ANNUAL VISIT LIMITS________

I HEREBY ASSIGN PAYMENT OF EAP AND/OR INSURANCE BENEFITS DIRECTLY TO PRESTON COUNSELING,PLLC. WHILE PRESTON COUNSELING, PLLC WILL BILL MY INSURANCE COMPANY, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED IF MY INSURANCE COMPANY DOES NOT PAY. _________

IT IS MY RESPONSIBILITY TO CONTACT MY EAP AND/OR INSURANCE COMPANY TO OBTAIN THE PROPER AUTHORIZATIONS IF REQUIRED. IF I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES. _________

IF YOUR PORTION OF THE BILL IS NOT PAID WITHIN 90 DAYS FROM THE LAST DATE IT WAS INCURRED A LETTER WILL SENT GIVING YOU 14 DAYS TO PAY YOUR ACCOUNT OR TO ARRANGE FOR A PAYMENT PLAN. IF YOU DO NOT RESPOND YOU WILL BE SENT TO COLLECTIONS. ______

A 1% INTEREST WILL BE ADDED TO YOUR PORTION OF THE BILL THAT REMAINS UNPAID AFTER 30 DAYS.____________

FEES ARE $________ FOR EACH SESSION. _______

YOU WILL BE CHARGED $80.00 FOR MISSING AN APPOINTMENT OR NOT GIVING AT LEAST 24 HOURS PRIOR NOTICE TO CANCELLING AN APPOINTMENT. ________

I HAVE RECEIVED THE TREATMENT AGREEMENT AND DISCLOSURE STATEMENT I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY EAP AND/OR INSURANCE COMPANY, IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

CLIENT SIGNATURE: ____**DATE**: __________________________

TO ENABLE MY THERAPIST WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT PRESTON COUNSELING PLLC'S OFFICE. CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN OUR OFFICE.

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY VOICE MAIL. _______YES _______NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME. ___YES ___NO EMAIL ADDRESS______________________________

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS.

____

____

CONCERNS AND GOALS:

PLEASE DESCRIBE WHY YOU HAVE COME IN: ____

____

DESCRIBE GOALS YOU WANT TO ACCOMPLISH BY COMING HERE: ____

____

____

PLEASE **CHECK** INDIVIDUAL ITEMS YOU WANT TO ADDRESS. PLEASE **CIRCLE** THE TWO MOST IMPORTANT, TO ADDRESS FIRST:

CONCENTRATION	FEARS	BOWEL TROUBLE	SELF-ESTEEM
HOPELESSNESS	GUILT	STOMACH TROUBLE	TEMPER
DEPRESSED	SELF-CONTROL	SEXUAL PROBLEM	RELAXATION
HARM TO SELF	HARM TO OTHERS	DRUG USE	FINANCES
SUICIDAL CONCERNS	IMPULSIVITY	ALCOHOL USE	WORK
HIGH ENERGY	HYPERACTIVE	HEADACHES	MOTIVATION
LOW ENERGY	ATTENTION DIFFICULTIES	MEMORY	LEGAL MATTERS
ANGER	SLEEP PROBLEMS	THOUGHTS	CAREER CHOICES
TEMPER	DREAMS	ABUSE	EDUCATION
NERVOUSNESS	NIGHTMARES	TRAUMA	MAKING DECISIONS
ANXIETY	HEALTH PROBLEMS	SHYNESS	MEANINGLESSNESS
STRESS	APPETITE/WEIGHT	CRYING SPELLS	UNRESOLVED GRIEF
PANIC	EATING/FOOD TROUBLE	UNHAPPINESS	SPIRITUAL CONCERNS

PLEASE **CHECK** RELATIONSHIP ITEMS YOU WANT TO ADDRESS. **UNDERLINE** THOSE YOU FEEL APPLY TO ANOTHER FAMILY MEMBER. PLEASE **CIRCLE** THE TWO MOST IMPORTANT TO ADDRESS FIRST.

MARRIAGE	PARENTING	RECREATION	FRIENDSHIPS
SEPARATION	CHILDREN	INFIDELITY/AFFAIRS	HOLDING OTHER DOWN
DIVORCE	HOUSING	PHYSICAL FIGHTING	CONFLICTING SCHEDULES
INTIMACY	FINANCES	COMMON INTERESTS	PROBLEM SOLVING
IN-LAWS	SEXUAL DESIRE	SHOWING APPRECIATION	LONELINESS
RELATIVES	AGREEING ON CHORES	TRUSTING EACH OTHER	COMMON GOALS
JEALOUSY	SEXUAL PERFORMANCE	AFFECTION	VERBAL FIGHTING
USE OF TIME	SPOUSE'S CLEANLINESS	COMMUNICATION	HAVING FUN TOGETHER

HEALTH INFORMATION:

LIST ALL CURRENT MEDICATIONS: ______________________________

____

LIST ALL CURRENT HEALTH PROBLEMS INCLUDING ALLERGIES: ______________________________

____

LIST PAST SIGNIFICANT HEALTH PROBLEMS: ______________________________

____

HAVE YOU BEEN HOSPITALIZED OR HAD OTHER PSYCHIATRIC CARE RELATED TO YOUR MENTAL HEALTH? ________

IF YES PLEASE PROVIDE DATES AND TREATMENT OUTCOME FOR THOSE EVENTS: ______________________________

____

LIST PREVIOUS PROFESSIONAL HELP, AND DATES YOU RECEIVED FOR PERSONAL, MARITAL, OR FAMILY CONCERNS:

____

____

NAME OF YOUR PRIMARY CARE PHYSICIAN: ____________________ MAY WE CONTACT? ____________________

PHONE NUMBER: ____________________ WHEN WERE YOU LAST SEEN? ______________________________

I GIVE MY **CONSENT** FOR MY THERAPIST TO RELEASE MY RECORD TO MY PRIMARY PHYICIAN SO THAT THEY CAN DISCUSS MY TREATMENT: SIGNED______________________________DATE______________

I DO NOT GIVE MY CONSENT FOR MY THERAPIST TO RELEASE MY RECORDS TO MY PRIMARY CARE DOCTOR TO DISCUSS MY TREATMENT: SIGNED______________________________DATE_______________

DRUG AND ALCOHOL ASSESSMENT;

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office?
________yes ________no
If yes __________self __________other: Relationship____

ALCOHOL ASSESSMENT:

Frequency of Alcohol use:
_____ Never ______ Less than1 time/month _____ 1-4 times per month _____ 2-3 times per week ______ Daily

Usual Alcohol Consumption:
______ None _______ 1-2 drinks per sitting ______3-4 drinks per sitting ________ 5 or more drinks per sitting

Frequency of use to levels of intoxication:
______ Never ______ less than 1 time/month ______ 1-4 times per month ______ 2-3 times per week ______ Daily

Please describe any alcohol-related problems (e.g. legal, job, physical, or social):______________________________

____

Self-perception of alcohol use: (check all that apply)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___ Attended AA/ other 12 step program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

OTHER SUBSTANCE USE ASSESSMENT: (Check Frequency and Duration for each drug used in the last 6 months)

	Frequency			**Duration**	
	Daily	Weekly	Monthly Or less	Less than one year	More than one Year
Marijuana	_____	_____	_____	_______	________
Sedative	_____	_____	_____	_______	________
Stimulant	_____	_____	_____	_______	________
Cocaine	_____	_____	_____	_______	________
Opiates	_____	_____	_____	_______	________
Inhalants	_____	_____	_____	_______	________
Hallucinogens	_____	_____	_____	_______	________
Prescription Drugs	_____	_____	_____	_______	________

Caffeine _____ Number of cups per day ______ Tobacco____ if cigarettes-number per day _______

Please describe any drug-related problems (e.g. legal, job, physical, or social) ________________________________

____

Self-perception of Drug Use: (check all that apply)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___ Attended NA/ other program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

LEGAL INFORMATION:

DO YOU HAVE ANY LEGAL ISSUES? IF YES, PLEASE
EXPLAIN:____
____
____
____
____

MARITAL INFORMATION:

MARRIED: ______ DIVORCED: _______ LIVING TOGETHER: _____ SEPARATED: _______ SINGLE: _______ OTHER: ______

IF YOU CHECKED "OTHER" PLEASE EXPLAIN: ____

LIST DATES AND LENGTHS OF ANY PREVIOUS MARRIAGES: ____
____

FAMILY HISTORY:

LIST THE NAMES, AGES, AND RELATIONSHIP, OF ALL PERSONS LIVING IN YOUR HOME:

____
____
____

LIST THE NAMES, AND AGES OF ANY IMMEDIATE FAMILY MEMBERS THAT ARE NOT LISTED ABOVE

____
____
____
____
____
____

RELIGOUS INFORMATION:
ARE SPIRITUAL ISSUES OF CONCERN TO YOU ___________YES __________NO

WHAT IS YOUR RELIGIOUS AFFILIATION, IF ANY? ____