

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 you 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 companies **including copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees 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 owned, 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: _____