ADULT INTAKE

DATE: _____

NAME: _____ AGE: _____ DOB: _____ SS#: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE#: _____ CELL PHONE#: _____

EMPLOYED BY: _____ WORK#: _____

SPOUSE (OR RESPONSIBLE PERSON): _____

ADDRESS: _____

HOME PHONE#: _____ W0RK PHONE#: _____

EMPLOYED BY: _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

REFERRED BY (OTHER THAN PCP): _____

OTHER PHYSICIAN: _____

SERIOUS ILLNESS/INJURIES: _____

HOSPITALIZATIONS: _____

OPERATIONS: _____

AMOUNT OR USE OF CIGARETTES, ALCOHOL, ILLICIT DRUGS: _____

_____

ALLERGIES (especially to medications): _____

CURRENT MEDICATIONS: _____

_____

PREVIOUS CONTACT WITH MENTAL HEALTH/SUBSTANCE PROFESSIONALS: _____
NAME

_____
DATE (S) REASON

PLEASE FILL OUT REVERSE SIDE

FAMILY HISTORY

DESCRIBE ANY MENTAL HEALTH PROBLEMS AMONG RELATIVES: _____

_____

DO YOU HAVE CHILDREN? YES_____NO_____ HOW MANY: _____

WHO IS LIVING IN YOUR HOME AND WHAT IS THEIR RELATIONSHIP TO YOU? _____

_____

**** PLEASE READ THE FOLLOWING AND SIGN BELOW ****

PAYMENT: I UNDERSTAND THAT FULL PAYMENT IS EXPECTED AT THE TIME OF EACH APPOINTMENT.

CANCELLATIONS: I UNDERSTAND THAT THERE WILL BE A FULL CHARGE FOR ANY VISIT NOT CANCELED 24 BUSINESS HOURS IN ADVANCE. I UNDERSTAND THAT THIS FEE IS MY RESPONSIBILITY AND CANNOT BE BILLED TO MY INSURANCE COMPANY.

_____
SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT

NOTICE OF PRIVACY PRACTICES: I, _____, hereby acknowledge
(Patient or Responsible Party)

that a copy of the Notice of Privacy Practices of _____ has been made available to me.
(Provider)

DATE:_____ _____
SIGNATURE OF PATIENT or PATIENT'S REPRESENTATIVE

_____
DESCRIPTION OF REPRESENTATIVE'S AUTHORITY

_____
FOR OFFICE USE ONLY

I, _____, delivered the Notice of Privacy Practices to
(Provider or Designee)

_____ on _____. I attempted to obtain an acknowledgment of
(Patient or Responsible Party)

the receipt of the Notice of Privacy Practices but was unable to do so because

_____

_____

DATE:_____ SIGNATURE OF PROVIDER OR DESIGNEE:_____