DR. TINA SCOTT, MA, LPC

CLIENT INTAKE FORM

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 30 minutes to complete.

Name:____

(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):____

(Last) (First) (Middle Initial)

Birth date: ______/______/______ Age:________ Gender: Male Female

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: ________ Ages:_________________________________

Current address: ____

____

Home phone:______________________________ May we leave a message? Yes No

Cell/other: _______________________________ May we leave a message? Yes No

Email:___________________________________ May we email you?* Yes No

*NOTE: Emails may not be confidential

Referred by:____

A copy of your Insurance & Drivers License is needed at the time of service. Please read the following carefully and sign below.

HEALTH INSURANCE INFORMATION

Insurance Company Name ______________________________Specialty copayment_______________________

Address ____ Phone# ________________________

Policy Holder's Name __________________________________ Policy Holder Birth Date ________________

Policy Holder's SS# _______________________ Relationship to Patient _________________________________

Policy ID# _____________________________________Group# _______________________________________

If there is a secondary insurance, complete the following:

Insurance Company Name ________________________________Specialty co-payment__________________________________

Address ____Phone# ____

Policy Holder's Name _______________________________________Policy Holder Birth Date ______________________________

Policy Holder's SS# _______________________ Relationship to Patient ____

Policy ID# ____Group# ____

Are you using EAP employee assistance program? ❑ Yes ❑ No

If yes what is the name and contact number for your EAP?___________________________

Authorization Number_________________________ Number of Authorized Session________

Assignment of Benefits and Release of Information

I give permission to Dr. Tina Scott and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 48 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions. I am aware that failure to pay unpaid balances will cause my account to be sent to collection agencies.

____ ________________

Signature of Responsible Party Date

1445 CITY AVE, WYNNEWOOD PA 19096~~215-519-2531

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Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No
Reason for change:____

Have you had any mental health services in the past? Yes No
Reason for change:____

Are you currently taking any psychiatric prescription medication? Yes No
If yes, please list:____

Have you been prescribed psychiatric prescription medication in the past? Yes No
If yes, please list:____

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): ____
____
____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other:____________________

How many times per week do you exercise? ____________________ days ____________________ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle one:

Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

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Do you consume alcohol regularly? Yes No

In one month, how many times do you have four or more drinks in a 24-hour period?______________________

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Have you felt depressed recently? Yes No

If yes, for how long?____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago?____

How often did you have these thoughts? Frequently Sometimes Rarely

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship?____

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _________________

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

____

____

Quick Check

Circle the issues below that apply to you.

Extreme depressed mood	Mood swings	Rapid speech	Extreme anxiety
Panic attacks	Phobias	Sleep disturbance	Hallucinations
Memory lapse	Alcohol/substance abuse	Body complaints	Eating disorder
Repetitive thoughts	Anxiety	Time loss	Repetitive behaviors
Homicidal thoughts	Suicide attempts	Trouble planning	Difficulty with relationships

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer?____

What is your position?____

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Are you happy in your current position?	Yes	No
Are you fulfilled in your current position?	Yes	No
Does your work make you stressed?	Yes	No

If yes, what are your work-related stressors?____

Religious/Spiritual Information

Do you practice a religion?	Yes	No

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual?	Yes	No

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	______________________
Anxiety Disorders	Yes	No	______________________
Bipolar Disorder	Yes	No	______________________
Panic Attacks	Yes	No	______________________
Alcohol/Substance Abuse	Yes	No	______________________
Eating Disorder	Yes	No	______________________
Learning Disability	Yes	No	______________________
Trauma History	Yes	No	______________________
Domestic Violence	Yes	No	______________________
Obesity	Yes	No	______________________
Obsessive Compulsive Behavior	Yes	No	______________________
Schizophrenia	Yes	No	______________________

Other Information

List your strengths ____

____

____

List areas you feel you need to develop ____

____

____

What do you like most about yourself? ____

____

____

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What are some ways you cope with life obstacles and stress?____

____

____

What are your goals for therapy/what would you like to accomplish? _____________________________________

____

____