



ADULT INTAKE QUESTIONNAIRE

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____

Address: _____

Home phone: _____ Ok to leave message? Yes No

Work phone: _____ Ok to leave message? Yes No

Cell phone: _____ Ok to leave message? Yes No

Email: _____

Referred by: _____

May we acknowledge the referral? _____

Reason you are seeking services:

Present psychological difficulties – please check any that apply to you at this time.

- Generalized Anxiety (across many situations)
- Specific fears/phobias (list): _____
- Panic attacks
- Social Anxiety
- Obsessive thinking or compulsive behaviors
- Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- Sadness or Depression
- Emotionally overwhelmed
- Frequent crying
- Loss of energy
- Loss of pleasure in life
- Self-injurious / Self-harm behavior
- Thoughts of suicide
- Problems with eating
- Problems falling asleep
- Problems sleeping through the night (middle of the night waking or early morning waking)
- Trouble waking up
- Fatigue/tiredness during the day
- Nightmares
- Problems with attention or concentration
- Racing thoughts
- Problems making or keeping friends
- Problems controlling temper
- Relationship/Marriage problems
- Problems with intimacy
- Problems with job
- History of abuse (emotional, physical, sexual)
- Alcohol/drug use/abuse
- Financial problems
- Legal situation

Other:

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

What do you wish to accomplish (what are your goals) in seeking services at this time?

FAMILY INFORMATION:

Marital Status (circle one):

Single Living with Partner Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ___ fair ___ poor ___ very poor

Your occupation: _____

Occupation of Spouse/Partner: _____

Children and ages:

If divorced, what are the custody arrangements?

Who currently resides in your home?

GENERAL HEALTH:

Your current health: _____ excellent _____ good _____ fair _____ poor

Primary Physician's name/address/phone number:

When was your last physical exam? Any relevant findings?

Are there any other physicians you see on a regular basis?

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

Any problems with sleep? Describe.

Any problems with eating? Describe.

Please rate the overall level of stress in your life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What do you consider to be the greatest source of stress at this time?

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). _____

Are you a past or present smoker? _____

Length of time, number of cigarettes and frequency: _____

Do you use alcohol? _____

Number of drinks and frequency: _____

Do you drink caffeinated beverages? _____

Number of drinks and frequency: _____

FAMILY HISTORY:

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
_____	Mental Retardation	_____
_____	Speech or Communication Disorder	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____

Other:

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Any problems with attention, learning, or behavior in school?

Grades repeated and reason:

Served in Special Education?

Additional Comments:

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain



NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff are not available, please call your therapist's extension and either leave a message or contact him/her through their cell phone or pager. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

If your doctor/therapist is out of town or unavailable for some other reason, one of our other doctors/therapists will be on-call.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by either your doctor/therapist or our office staff.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your doctor/therapist will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need.

Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit. In addition, because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your therapist's voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered. Any other arrangement is considered a special arrangement and must be discussed in advance with your therapist. Delinquent accounts may be referred to a collection agency.

We accept checks, Visa, and Mastercard.

For some therapists, collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim. Additional copies can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: _____

Client's Name

Client's Signature



INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by _____.
(BIA clinician)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold _____ harmless for releasing information under the above conditions.
(BIA clinician)

Client's Name: _____

Date of birth: _____

Signature: _____

Date: _____



PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby authorize _____ to release and discuss the results of my
(BIA clinician)

___ Psychological Evaluation/Testing

___ Treatment/Therapy

with the following individuals. I also give those listed below my permission to discuss and release
information regarding my care to _____.
(BIA clinician)

This release of information is valid from _____ (date) to _____ (date).

Individual	Agency	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Client name (print): _____

Date of birth: _____

Signature: _____

Date: _____