Insight Therapeutic Services, LLC

INDIVIDUAL INTAKE

CLIENT'S FULL NAME: _____TODAY'S DATE: _____

CLIENT'S ADDRESS: _____

CITY STATE ZIP: _____

TELEPHONE: HOME _____CELL_____WORK _____

EMAIL: _____ SSN: _____

AGE: _____ BIRTHDATE: _____ RACE: _____ GENDER: _____

SCHOOL (IF STUDENT): _____

REFERRED BY: _____PHONE:_____

PARENT/GUARDIAN'S FULL NAME: _____

PARENT/GUARDIAN'S ADDRESS: _____

CITY STATE ZIP:_____

TELEPHONE: HOME _____CELL_____WORK _____

EMAIL: _____

PERSON TO CONTACT IN AN EMERGENCY: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION

NAME OF INSURED: _____

RELATIONIONSHIP TO CLIENT: _____

INSURED'S DOB: _____ INSURED'S SSN: _____

INSURANCE CARRIER: _____

CONTRACT #:_____ GROUP #: _____

AMOUNT OF CO PAY: _____ DEDUCTIBLE REMAINING: _____

NAME OF PRIMARY CARE PHYSICIAN: _____ ADDRESS: _____

PHONE NUMBER: _____ WHEN WAS CLIENT 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_____

TO ENABLE THE THERAPIST WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:
PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT THE ITS COUNSELING OFFICE AND ARE DISTRIBUTED TO THE INDIVIDUAL THERAPIST. 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 (IF DIFFERENT FROM PAGE 1): _____

NAME OF ALTERNATE CONTACT: _____ PHONE NUMBER: _____

MAY WE COMMUNICATE WITH THEM IN CASE WE CAN'T REACH YOU? YES _____ NO_____

SIGNED_____ DATE_____

HEALTH INFORMATION:

LIST ALL CURRENT MEDICATIONS:
_____
_____

LIST ALL CURRENT HEALTH PROBLEMS INCLUDING ALLERGIES:
_____
_____

LIST PAST SIGNIFICANT HEALTH PROBLEMS:
_____
_____

HAVE YOU HAD ANY INPATIENT OR OUTPATIENT CARE RELATED TO YOUR MENTAL HEALTH? YES _____ NO_____

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

LEGAL INFORMATION

DOES THE CLIENT HAVE A CASE WORKER OR PROBATION OFFICER: YES _____ NO _____

IF SO, NAME OF WORKER: _____

PHONE NUMBER: _____

DOES THE CLIENT HAVE AN ATTORNEY: YES _____ NO _____ NAME: _____

DOES THE FAMILY HAVE PRIOR DHR INVOLVEMENT: YES _____ NO _____

IF SO, REASON FOR PAST OR PRESENT INVOLVEMENT: _____

EDUCATIONAL HISTORY

CURRENT SCHOOL (If Student): _____ SCHOOL PHONE NUMBER: _____

TYPE OF SCHOOL: ____PUBLIC _____PRIVATE _____HOME SCHOOLED _____OTHER (SPECIFY):_____

HIGHEST GRADE LEVEL COMPLETED: _____

HAS THE CLIENT BEEN TESTED PSYCHOLOGICALY? _____YES _____NO
IF YES, DESCRIBE: _____
_____

DOES THE CHILD EXHIBIT CONDUCT PROBLEMS AT SCHOOL WITH TEACHERS AND/OR PEERS?_____
_____
_____

PAST YEAR – SUSPENSIONS? _____ ABSENCES? _____ FIGHTS? _____

_____ _____

CLIENT SIGNATURE DATE