PATIENT INTAKE FORM

Your name:_____

Address: _____

_____

Email address: _____

Date of Birth_____

Telephone Number:_____ **Email address:**_____

Person to contact in an emergency:_____ **(Relationship)** _____ **Phone number:**_____

Religion _____ **Ethnicity** _____ **Education** _____

Occupation (if not retired) _____

Name and age of your parents: _____

Name & ages of brothers & sisters_____

Names & ages of children:_____
_____

Describe your childhood to the best of your ability (use back of page if necessary:_____ _____

_____

_____

_____

_____

_____

_____

Please list any illnesses – physical or psychological including treatment for mental health and/or addictions with dates of treatment:

_____

_____

_____

_____

_____

Please state in your own words, the reason for your visit:

_____

_____

_____

Goals for Therapy:

_____

_____

_____

Previous Counseling History:

_____

_____

_____

Successes and/or dissatisfaction(s) with previous therapy and why:

_____

_____

_____

Please circle any of the following that apply to you:

Depression	**Worrying Excessively**	**Hearing voices**
Feeling hopeless	**Feeling worthless**	**Seeing things**
Too anxious to rest	**People are against you**	**Tension**
Poor energy	**Not interest in doing anything**	**Panic attacks**
No appetite	**Nightmares about the past**	**Drinking too much**
Too many drugs	**Fatigue**	**Can't focus**
Sleep problems	**Repetitive thoughts**	**Over-eating**
Excessive energy	**Unexplained euphoria**	**Compulsive**
Phobias/fears	**Memory problems**	**Can't concentrate**
Tics or jerks	**Easily get lost**	**Forgetfulness**
Sleep too much	**No energy to for self-care**	**Talk too fast**
Impulsive spending	**Can't get house clean**	**Racing thoughts**
Hyperactive	**Lethargic**	**Loss of time**

Please list all medication you are currently taking:

_____

_____

Who referred you? _____

Name of Service Animal: _____ Breed _____ Weight_____

Please read carefully and initial the following:

_____ Payment is due at time of visit.

_____ Insurance is not accepted, but paperwork for reimbursement will be completed for you.

_____ This time is reserved for you, therefor 48 hours cancellation is requested, you will be offered a makeup and payment is due.

____ If you are not physically capable of keeping a scheduled, (or make-up) appointment, a phone or Skype session will be offered to you.

____ Therapy will not work without mutual trust. We are both expected to keep our appointments.

____ No emails or text messages to cancel appointments - by phone only.

____ When it is time to stop therapy, you agree to a final session for closure.

Extra writing space:

Directions to office

250 Royal Palm Way, The Northern Trust Building
Suite 305

Lake I95 to Okeechobee. Exit east. A couple of miles east and go over bridge to Palm Beach. You will be on Royal Palm Way.

250 Royal Palm Way, the building is on the corner of a Hibiscus and Royal Palm Way. Suite 305B. Parking is behind building, 2nd entrance marked “Visitor” or on Hibiscus. (The building requires masks in the common areas of the building.) Go into suite 305, on 3rd floor, and have a seat in the waiting room, I will be with you at your appointment time.