

# CLIENT INTAKE FORM

## Client Information:

**Name:** Last \_\_\_\_\_ Middle Initial \_\_\_\_\_ First \_\_\_\_\_  
**Title:** Mr. \_\_\_ Mrs. \_\_\_ Ms \_\_\_ Dr. \_\_\_ **Suffix:** Jr. \_\_\_ Sr. \_\_\_ First \_\_\_ Second \_\_\_ Third \_\_\_  
**Sex:** Male \_\_\_ Female \_\_\_ **D.O.B.:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Other) \_\_\_\_\_  
**Email (optional):** \_\_\_\_\_ May we contact you via email? Yes \_\_\_ No \_\_\_  
**Relationship Status:** Married \_\_\_ Divorced \_\_\_ Single \_\_\_ In Relationship \_\_\_ Widowed \_\_\_ Separated \_\_\_  
**Employer:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Circle One:** Full-time / Part-time / Student / Retired / Unemployed

**Emergency Contact:** Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Please fill out the following information if another party is financially responsible for all professional services rendered to you at this office:

Name of Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Individual's Name: Last \_\_\_\_\_ Middle Initial \_\_\_\_\_ First \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**How did you hear about our office?** Work ( ) EAP ( ) Friend ( ) Dr. ( ) Psychiatrist ( ) Hospital ( )

**Primary Care Physician / Medical Information:** Do we have permission to contact your physician? Y \_\_\_ N \_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Psychiatrist:** Do we have permission to contact your psychiatrist? Y \_\_\_ N \_\_\_

Name of Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By signing below, you authorize this office to contact your physician and/or your psychiatrist (as indicated above), and to inform your doctor and/or psychiatrist of your mental health therapy.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## List any medications you are currently taking:

Name: \_\_\_\_\_ Generic?: \_\_\_ Date began: \_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Generic?: \_\_\_ Date began: \_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Generic?: \_\_\_ Date began: \_\_\_ Purpose: \_\_\_\_\_

## List any past medications:

Name: \_\_\_\_\_ Generic?: \_\_\_ Date began: \_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Generic?: \_\_\_ Date began: \_\_\_ Purpose: \_\_\_\_\_

Are you allergic to any medications? Y \_\_\_ N \_\_\_ If yes, list them here: \_\_\_\_\_

Medical conditions you are currently being treated for: \_\_\_\_\_

## Insurance Policy Holder Information:

Primary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder D.O.B.: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M ( ) F ( ) Insured relationship to client: \_\_\_\_\_

Policy Holder Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Individual Policy #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder D.O.B.: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M ( ) F ( ) Insured relationship to client: \_\_\_\_\_

Policy Holder Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Individual Policy #: \_\_\_\_\_

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Client Last Name

First Name

Date

<b>Feelings:</b>	<b>A Little</b>	<b>A Lot</b>	<b>Comments</b>
Sad			
Anxious			
Stressed			
Scared			
Lonely			
Guilty			
Frustrated			
Angry			
Degraded			
<b>Problems:</b>			
At Home			
At School			
At Work			
In my Social Arena			
Sleeping			
Eating			
Weight Gain			
Weight Loss			
<b>Harm to Self/Others:</b>			
I have hurt someone in the past			
I have thoughts of hurting someone			
I have thoughts of hurting myself			
<b>Support:</b>			
I have close friends to talk to			
I have family that is there for me			
<b>Self Worth:</b>			
I feel confident in my abilities to solve problems			
I feel good about myself			

**List areas of concern (in order of priority):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**What dates have you previously been in counseling, and for how long?**

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**FOR OFFICE USE ONLY**

First session date: \_\_\_\_\_

DSM-IV Diagnosis: Axis I: \_\_\_\_\_ Code: \_\_\_\_\_

Axis II: \_\_\_\_\_ Code: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF  
KOPP'S COUNSELING – NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the Kopp's Counseling – Notice of Privacy Practices.  
I understand that the privacy practices described in this notice are effective as of February 22, 2013.

Participant's Name (print) \_\_\_\_\_

Participant's or Guardian's Signature: \_\_\_\_\_

Signature Date: \_\_\_\_\_

## MISSED SESSION / CANCELLATION FEE POLICY AS OF 06/01/15

**If you miss your appointment, or cancel your appointment, with less than 24-hour notice, you will be charged \$65.00.** This fee is not billable to your insurance company. You, the patient, will be personally responsible for paying this fee at, or prior to, the next scheduled session. If do not schedule another session, an invoice will be mailed to your address on file, and it must be paid within 30 calendar days. **If you incur multiple fees, and/or the fees remain unpaid for 30 days or more, it may prevent you from scheduling a future session, at the discretion of the therapist.**

**This fee will be applicable regardless of the reason for missing a session, including but not limited to: forgetting the appointment, work-related matters, scheduling conflict, family issues, personal difficulties, transportation problems, and/or sickness, etc.**

Special considerations may be made in extreme circumstances (such as an accident, serious illness, or hospitalization), but we may require you to provide documentation to support your claim.

This policy is in place out of respect for all of our clients. Cancellations with less than 24-hour notice are difficult to fill, and by giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

**By signing below, you acknowledge that you have read and accept the Missed Session / Cancellation Policy for Kopp's Counseling as described above.**

Thank you for your understanding and cooperation.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date