CRESTVIEW
Psychological Testing & Counseling Center

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CRESTVIEW PSYCHOLOGICAL TESTING & COUNSELING CENTER
PATIENT INTAKE FORM

Providing you with the best possible care is of the utmost importance to me. To assist in meeting your needs, please fill out this form completely in ink.

Patient's First Name: _____ Middle Initial: ___ Last _____
Street Address: _____
City _____ State _____Zip_____
Preferred Phone #: (_____) _____
Birth Date: _____/_____/ _____ Race_____
Gender: _____ Female _____ Male
Email address: _____ Marital status: SGL MAR WID SEP DIV
Patient employed? _____ No _____ Yes Employer:_____
Patient a student? _____ Part-time _____ Full-time School: _____

INSURANCE INFORMATION

Insured's I.D. #: _____ Primary Insurance Company: _____
Insured's Name, if different than patient (Last, First, Middle) _____, _____
Patient relationship to insured: ___ Self ___Spouse ___ Child ___ Other
Policy #: _____ Group #: _____ Insured's Birth Date: _____/_____/_____ Gender: __F__M
Insured's employer: _____ Insurance Plan Name: _____

I authorize the release of any information necessary to process insurance claims. I also authorize Crestview Psychological Testing & Counseling Center to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Crestview Psychological Testing & Counseling Center (or to the party that accepts assignment). I permit a copy of this authorization to be used in the place of the original.

I certify that all the information I have reported with regard to my insurance coverage is correct.
This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____

Who referred you? _____

May we send a Thank You note to the referral source? ___ Yes ___ No If Yes, please initial here: __

What is the reason you are seeking treatment at this time?

_____
_____
_____
_____

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FAMILY HISTORY

Spouse's First Name: _____ MI: _____ Last Name: _____
Spouse's Birth Date: _____/_____/_____ Date of Marriage: _____
Other Marriages: _____
Children:
Name: Age Gender Living at home? Occupation Marital Status

_____
_____
_____

	Father	*Mother*
Name:	_____	_____
Is he/she living?	_____	_____
Health Status	_____	_____
Occupation:	_____	_____
If deceased, what is the cause and date of death?		
Cause:	_____	_____
Date:	_____	_____

Siblings
Name: Age Gender

_____
_____
_____
_____

What is your numerical order in the family? _____
Have there been any emotional or mental disorders within the family? _____
Any that required hospitalization? _____
Education: How many years of schooling have you had? _____ Degrees earned? _____
Current Living Situation: (Mark all that apply)

Live alone With spouse With children With parents With others
With sibling(s) With other relative(s) In an institution

Religion: ___ Protestant ___ Roman Catholic ___ Jewish ___ Other ___ None. Active _____ Inactive

GENERAL MEDICAL HISTORY

Name of Primary Care Physician: _____
Name(s) of other physicians currently treating you: _____
Current medications you are taking: _____ List any medication allergies: _____
List any previous surgeries or hospitalizations: _____
Do you smoke? _____ Yes. _____ No. If yes, how much? _____ Interested in stopping? _
Do you regularly drink alcohol? _____ Yes. _____ No. If yes, how many ounces/beers per day? _____
If yes, in what form? (Check all that apply) _____ Beer _____ Whiskey _____ Wine _____ Mixed drinks
Do you have a history of using illegal/recreational drugs or abusing medications? _____ Yes _____ No
If yes to illegal drugs, what drugs? _____
Are you currently under a lot of pressure at home or work? _____ Yes. _____ No

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GENERAL MEDICAL HISTORY (CONTINUED)

Please check if you have had any of the following: What treatment did you require?

_____ Ulcers _____ Colitis _____ Asthma _____

_____ Depression _____ Suicide Attempts _____

_____ Manic-Depressive Disorder (Bipolar disorder) _____

_____ Schizophrenia _____ Paranoid Thinking _____

_____ Hallucinations _____ Delusions _____

_____ Obesity _____ Eating disorder _____

_____ Chemical Abuse/Dependency _____

_____ Severe Anxiety _____ Irrational Fears _____

_____ Sexual Abuse _____ Physical Abuse _____

_____ Chest pain, pressure, tightening _____

_____ Dizzy spells Memory loss _____

Time since last psychiatric or counseling service:

① No prior service ② Within the same day ③ Within seven days ④ Within 30 days

⑤ Within six months ⑥ Within one year ⑦ Over one year

Were you treated inpatient _____ or outpatient? _____ (Check all that apply)

List all previous therapist(s) and counseling experience: _____

_____

Have you formally terminated counseling with your previous therapist? _____ Yes _____ No _____N/A

RESPONSIBLE PARTY INFORMATION

First Name: _____ MI: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: ___

Home Phone#: (____) _____ Work Phone#: (____) _____ Fax #: (____) _____

E-mail:_____ Gender: ___ Female ___ Male

If the Patient is a minor under 18 years of age: Name of person accompanying the patient:

_____

Relationship to Patient: _____. I certify that I have the legal right to seek treatment, and do authorize Crestview Psychological Testing & Counseling Center to provide treatment to the above registered patient. I also understand, as the person authorizing treatment, I am responsible for payment of services provided.

Signature: _____ Date: _____

CANCELLATION/MISSED APPOINTMENTS

I understand that it may, at times, be necessary to cancel an appointment. To help me be most efficient and responsible in the use of my time, I require that any changes or cancellations be made at least 24 hours in advance, Monday through Friday. If there's a need to cancel a Monday appointment, that cancellation would need to be made by the Friday before the appointment. Any changes or cancellations received less than 24 hours in advance will be charged a $50 cancellation fee. Any missed appointments with no call received will be charged to your account. Most insurance companies do not cover missed appointment charges.

I understand that I am financially responsible for all charges whether or not covered by my insurance.

Please initial here. ___