

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Relationship Status:

Never Married Domestic Partnership Married Separated

Divorced Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () May we leave a message? Yes No

Cell/Other Phone: () May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (how did you find me?) _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- Yes
- No

Please list: _____

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
 Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
 Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage recreational drug use? Daily Weekly Monthly
 Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

Susan E. Hammonds-White, Ed.D., LPC/MHSP
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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data: the transaction rules, the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers including mental health care. All health care providers and agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

The HIPAA law and regulations are extremely detailed and somewhat lengthy. This Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important that you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and, as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Susan E. Hammonds-White, Ed.D.
Licensed Professional Counselor/MHSP

I, _____, understand and have been provided a copy of Dr. Susan Hammonds-White’s Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, and well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

Patient Signature of Parent if Minor or Legal Charge

Date

If Legal Charge, Name of Identified client _____