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ADULT INTAKE INFORMATION FORM

Name: _____ DOB:_____ Sex: ____ Social Security #_____

Address: _____ Zip _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Primary purpose of your visit to this office: _____

_____

I. REFERRAL INFORMATION:

Who suggested you consult me? _____

Ever received services from other mental health professional(s) (who, what & when)? _____

_____

II. PAYMENT INFORMATION: Payment of my fee is expected at the time of your appointment unless you have made another arrangement with me. If you would like to file claims for reimbursement by your insurance provider, let me know if you would like my office to provide you with a monthly statement to be utilized for this process. If you would like my office to file insurance claims for you, please attach a copy of the front and back of your insurance card.

III. MEDICAL HISTORY:

Current/Past Medical Problems: _____

_____

Current Medications: _____

IV. PERSONAL HISTORY:

Your current marital status (check all that apply):

Married_____; Unmarried_____; Divorced_____(# of times)

If children, number of children ___ ; Biological ___ Adopted___Step___

Name _____ Sex ___ Age ___ Lives with you? ___

Name _____ Sex ___ Age ___ Lives with you? ___

Name _____ Sex ___ Age ___ Lives with you? ___

Have you experienced any of the following? (Check all that apply):

___ Depression ___Suicidal ___ Drug Abuse ___Alcohol Abuse ___Seizures
___Anxiety, Phobia or Panic Attack ___Schizophrenia or Psychosis
___Manic Depression, Bipolar Disorder, or Mood Swings ___ Attention Problems
___Developmental Delay or Mental Retardation ___ Learning Problems ___ Sexual Abuse
___Physical Abuse, Domestic Violence ___ Major Accidents/Injuries ___Neglect
___Psychiatric Hospitalization ___Legal Problems/Incarceration

V. FAMILY HISTORY: The following applies to the family in which you grew up, even if these are NOT your biological parents.

Mother	Father
Occupation: _____	Occupation: _____
Education: _____	Education: _____
General Health: _____	General Health: _____
Serious illness: _____	Serious illness: _____
If living, current age: _____	If living, current age: _____

Family History of (indicate "M" for Mother's side and "F" for Father's side)

___ Depression ___Suicidal ___Drug Abuse ___Alcohol Abuse ___Seizures
___Anxiety, Phobia, or Panic Attack ___ Schizophrenia or Psychosis
___Manic Depression, Bipolar Disorder, or Mood Swings ___Attention Problems
___Developmental Delay or Mental Retardation ___Learning Problems ___Sexual Abuse
___Physical Abuse, Domestic Violence ___Neglect ___Psychiatric Hospitalization
___Legal Problems/Incarceration

VI. UNDERSTAINDING OF CONFIDENTIALITY:

I understand that the information that I/we provide to Dr. Scalf-McIver will remain confidential unless I provide my written or verbal consent for her to release that information. However, confidentiality will not be kept by Dr. Scalf-McIver in the following circumstances: 1) If she judges that there is a threat to the physical safety of myself or others (e.g. threatening to kill or hurt self or others); 2) If she becomes aware that a child or elder is possibly being physically or sexually abused or neglected; or 3) If I/we engage in a legal action in which I/we hold out my/our emotional or mental status as an issue.

_____ _____
Signature of Client Date

VII: FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT:

I authorize treatment or evaluations of the client named and agree to take responsibility for all fees and charges for such treatment. Although my insurance may reimburse Dr. Scalf-McIver or me for many of these charges, I understand that I am responsible for full payment or insurance co-payment for services at the time they are rendered unless other arrangements have been made with Dr. Scalf-McIver.

Appointments with Dr. Scalf-McIver may be cancelled with 72 hours (3 business days) or more advance notice without any service charge to my account. However, if I cancel my appointment **less than 72 hours (3 business days) prior to the scheduled time, the full fee for the session will be charged.** If I do not show up for a session, the full fee will be charged.

_____ _____
Signature of Client or Responsible Party Date

VIII. INSURANCE RELEASE:

I authorize the release of information necessary to process my insurance claims. It is understood that such information is confidential and solely for the purpose of insurance claims. This authorization will remain in effect until rescinded in writing. A photocopy will be as valid as the original.

_____ _____
Signature of Client Date

IX. UNDERSTANDING OF COMMUNICATION:

Although we live in an age in which texting, instant messaging, and emailing are common, Dr. Scalf-McIver does not use any of these forms of communication as a part of her mental health practice. She WILL respond to direct verbal communication in person, on the phone, or via messages left on her confidential voicemail. This practice is to promote healthy, direct expression of thoughts and feelings, to facilitate accurate understanding of what is being communicated, and to protect patients' privacy. My signature below indicates my understanding of this communication policy.

_____ _____

Signature of Client Date