

# **GREG FORD CLIENT INTAKE FORM**

PLEASE FILL OUT BOTH SIDES COMPLETELY.

Patient Name: _____		Social Security #: _____	
Mailing Address: _____			
City/State/Zip _____			
		Picture ID Copied <input type="checkbox"/>	Verified <input type="checkbox"/>
Home Phone # _____	Work Phone # _____	Cell Phone # _____	
<i>OK to leave message? YES/NO</i>	<i>YES/NO</i>	<i>YES/NO</i>	
Date of Birth: _____	Referred by: _____		
Sex: FEMALE / MALE / _____	Primary Care Physician: _____		
Employer / School _____	Position/Grade _____		
Employer Address _____			
Emergency contact _____		Phone # _____	
If visit is related to auto accident:		Date of Accident: _____	State: _____

## **PRIMARY INSURANCE**

## **SECONDARY INSURANCE**

Insurance Co.: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_  
*(this may be a social security #)*

Policy ID Number: \_\_\_\_\_  
*(this may be a social security #)*

Group Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder's Name:  
\_\_\_\_\_

Policy Holder's Name:  
\_\_\_\_\_

Relationship to you: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Policy Holder date of birth: \_\_\_\_\_

Policy Holder date of birth: \_\_\_\_\_

## **AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT**

*I hereby authorize Dr. Greg Ford to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to Dr. Greg Ford. I acknowledge that I have received or been offered the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# GREG FORD INTAKE INFORMATION

## PERSONAL INFORMATION

Where were you born/raised? \_\_\_\_\_

Are you currently practicing a religion / faith system? \_\_\_\_\_

What, if any, religious / faith traditions were important in your upbringing? \_\_\_\_\_

\_\_\_\_\_

Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

## MEDICAL HISTORY

LIST ALL PREVIOUS AND CURRENT *PSYCHIATRIC* MEDICATIONS:

Drug Name	Strength	Times/Day	Approximate start/end date	Results

ALL *OTHER* CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Please list all current health care providers: \_\_\_\_\_

\_\_\_\_\_

Current medical (non-psychiatric) illnesses, problems, issues. Please be as complete as possible:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous medical illnesses, problems, and surgeries (include dates):

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Allergies to medicines: \_\_\_\_\_

Alcohol/Drug/Tobacco/Caffeine use:

Past: \_\_\_\_\_

Present: \_\_\_\_\_

### MENTAL HEALTH HISTORY

Have you had mental health problems in the past (please explain)? \_\_\_\_\_

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Have you sought treatment for this or other mental health problems? Was it helpful? \_\_\_\_\_

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Were you ever hospitalized for psychiatric reasons? If so, when and where?

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Have any of your relatives had problems with their mental health? If so, please describe: \_\_\_\_\_

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### FAMILY SITUATION

RELATIONSHIP STATUS: single    involved    engaged    cohabitating

                                         married    separated    divorced    widowed

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

Others living in your home, ages, relationship: \_\_\_\_\_

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Your sources of social/emotional support (family, friends, spiritual community, etc.):

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Current sources of income (circle all that apply)

Employment Retirement Disability Family Savings/Investments Other: \_\_\_\_\_

EMPLOYMENT: (circle all that apply)

Full time Part Time Current Occupation: \_\_\_\_\_

Retired Disabled Student Homemaker

Past Occupations: \_\_\_\_\_

**GOALS FOR THERAPY/EVALUATION**

What would you like to see happen as a result of your work here? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed (Patient signature)

Date

***SECTION BELOW IS FOR OFFICE USE ONLY.***

**CLINICIAN'S NOTES (for office use only)**

Clinician Name: \_\_\_\_\_

Date	DX code	Diagnosis	Clinician signature