KATE HASKELL CLIENT INTAKE FORM

PLEASE FILL OUT BOTH SIDES COMPLETELY.

Patient Name:_____ Social Security #:_____

Mailing Address:_____

City/State/Zip_____

Picture ID Copied ☐ Verified ☐

Home Phone #_____ Work Phone #_____ Cell Phone # _____
OK to leave message? YES/NO *YES/NO* *YES/NO*

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

Insurance Co.:_____

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

Group Number: _____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth: _____

SECONDARY INSURANCE

Insurance Co.:_____

Policy ID Number:_____
(this may be a social security #)

Group Number:_____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth:_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT

I hereby authorize Kate Haskell 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 Kate Haskell. I acknowledge that I have read 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

KATE HASKELL 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):

_____

_____

_____

Allergies to medicines: _____

Alcohol/Drug/Tobacco/Caffeine use:

Past: _____

Present:_____

MENTAL HEALTH HISTORY

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

_____

_____

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

_____

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

_____

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

_____

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: _____

_____

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

_____

_____

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