Pinnacle ADHD Counseling LLC

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Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask for clarification if you do not understand an item.

ADULT INTAKE FORM

Patient INFORMATION:

FULL NAME: _____ _____ DATE: _____

MAILING ADDRESS: _____ _____
(STREET OR PO BOX NUMBER)

_____
(CITY, STATE, ZIP CODE)

Email address:_____

TELEPHONE: _____AGE: _____ BIRTH DATE: _____ SEX: ___M _____F

RACE/ETHNICITY: _____ BIRTHPLACE: _____

OCCUPATION:_____ PLACE OF EMPLOYMENT: _____

FULL TIME___ OR PART TIME_____

SIGNIFICANT OTHER INFORMATION:

NAME: _____(PHONE IF DIFFERENT) _____

ADDRESS (IF DIFFERENT):_____
Street or P.O. Box

_____
City State Zip Code

EMPLOYER: _____ WORK PHONE: _____

OCCUPATIONAL TITLE: _____FULL TIME: _____ PART TIME: _____

RACE / ETHNICITY: _____ AGE_____

REFERRED BY: _____PHONE:_____

To be completed by therapist:

Primary Diagnosis_____ Secondary Diagnosis_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

NAME OF THE INSURED: _____ INSURED'S D.O.B.: _____

INSURED'S SSN #: _____ INSURED'S GROUP #: _____

EMPLOYER: _____ AMOUNT OF CO PAY: _____

Insurance ID #_____

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, OR ANOTHER PARTY, PLEASE LIST THE NAME OF THE PROGRAM OR PERSON, HOW MUCH THEY ARE PAYING FOR, AND HOW MANY SESSIONS ARE BEING AUTHOURIZED.NAME_____AMOUNT_____# OF SESSIONS_____

TREATMENT AGREEMENT:

PLEASE INITIAL**:**

CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. _____

I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO PINNACLE ADHD COUNSELING AND CARA DIXON-TALIAFERRO._____

IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO OBTAIN PROPER AUTHORIZATION IF REQUIRED. IF I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED. _____

IF YOUR PORTION OF THE BILL IS NOT PAID WITHIN 90 DAYS FROM THE LAST DATE IT WAS INCURRED A LETTER WILL SENT GIVING YOU 10 DAYS TO PAY YOUR ACCOUNT OR TO ARRANGE FOR A PAYMENT PLAN. IF YOU DO NOT RESPOND, YOU WILL BE SENT TO COLLECTIONS_____

A 1% INTEREST WILL BE ADDED TO YOUR PORTION OF THE BILL THAT REMAINS UNPAID AFTER 30 DAYS_____

ASSESSMENT SESSIONS ARE $80.00 EVERY SESSION AFTER THAT IS $60.00 AND GROUPS ARE $25.00 _____

YOU WILL BE CHARGED $30.00 FOR NOT GIVING US 24 HOURS NOTICE, WHEN CANCELING AN APPOINTMENT. _____

THERE ARE NO GUARANTEES WITH PSYCHOTHERAPY. HOWEVER, WE ARE COMMITTED TO APPLYING THERAPY TECHNIQUES THAT ARE PROVEN IN RESEARCH. FURTHERMORE, WE TAILOR TREATMENT PLANS TO THE CLIENT'S NEEDS AND BASED ON ASSESSMENT RESULTS.

I HAVE RECEIVED THE TREATMENT AGREEMENT AND DISCLOSURE STATEMENT I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

CLIENT SIGNATURE: _____**DATE**: _____

SIGNATURE OF RESPONSIBLE PARTY_____**DATE**_____

TO ENABLE OUR STAFF WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY ANSWERING MACHINE. ___YES ___NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME _____YES _____NO MY EMAIL ADDRESS_____

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS._____

_____

HISTORY OF CURRENT PROBLEM:

DESCRIBE THE PROBLEM: ___

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF OUR WORK TOGETHER: _

___

___

___

____-

WHEN DID THE PROBLEM BEGIN? _____

Any history of Psychiatric hospitalization? -_____

_____

WHAT HAS BEEN DONE TO HELP WITH THE PROBLEM?

___

___

Any Suicide Attempts: How many: _____ Dates: _____

B**ACKGROUND INFORMATION**

MARITAL STATUS:_____

LIVING TOGETHER SINCE: _____ SEPARATED SINCE: _____ MARRIED SINCE:

DIVORCED SINCE: _____ WIDOWED SINCE: _____ CURRENT LIVING SITUATION: _____

PREVIOUS MARRIAGES: _____

ANY SIGNIFICANT MEDICAL PROBLEMS? _____ IF YES PLEASE DESCRIBE: ___

_____

ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? _____IF YES, PLEASE DESCRIBE: _____

WHEN DID A PHYSICIAN LAST EXAMINE THE YOU? _____

ANY PSYCHIATRIC COUNSELING? _____ IF YES, WHEN AND WHY? _____

ANY HISTORY OF ALCOHOL ADDICTION?_____ IF YES, HAVE YOU BEEN TREATED FOR IT_____

ANY HISTORY OF ABUSE OR ADDICTION TO RECREATIONAL OR PRESCRIBED DRUGS?_____
IF YES LIST_____

HAVE YOU BEEN TREATED FOR IT?_____

NAME OF PRIMARY CARE PHYSICIAN: _____ MAY WE CONTACT? _____

PHYSICIAN'S ADDRESS: _____ PHONE: _____

PSYCHIATRIC &/OR SUBSTANCE ABUSE TREATMENT CENTER NAME:_____

MAY WE CONTACT?_____PHONE_____

ADDRESS:_____

I GIVE MY **CONSENT** FOR MY TREATMENT PROVIDER TO EXCHANGE MY RECORD WITH MY PHYSICIAN SO THAT THEY CAN DISCUSS AND COLLABORATE ON MY TREATMENT: SIGNED_____DATE_____

I DO NOT GIVE MY CONSENT FOR MY TREATMENT PROVIDER TO RELEASE MY RECORDS TO MY PRIMARY CARE DOCTOR TO DISCUSS MY TREATMENT: SIGHED_____DATE_____

Significant other INFORMATION:

ANY SIGNIFICANT MEDICAL PROBLEMS? _____ IF YES PLEASE DESCRIBE: _

_____

ANY SERIOUS ILLNESSES, ACCIDENTS, AND SURGERIES? _____ IF YES PLEASE DESCRIBE: _____

_____

ANY PSYCHIATRIC COUNSELING? _____ IF YES, WHEN AND WHY? _____
HISTORY OF SUBSTANCE ABUSE_____TREATMENT FOR SUBSTANCE ABUSE_____

PATIENT WORK HISTORY

NUMBER OF JOBS IN THE PAST 5 YEARS? _____DO YOU HAVE PROBLEMS IN CURENT JOB? __ IF YES, EXPLAIN:

_____

HOW WOULD YOU RATE YOUR JOB PERFORMANCE: _____

HAVE YOU EVER BEEN HELD FIRED OR DEMOTED FROM YOUR JOB?: _____

IF YES, EXPLAIN WHY AND WHEN: _____

_____

HAVE YOU EVER BEEN ON DISABILITY? _____ IF YES, EXPLAIN WHY AND WHEN:
_____
_____
___

LEGAL ISSUES:

HAVE YOU EVER BEEN ARRESTED OR ON PROBATION? _____ IF YES PLEASE EXPLAIN: ____
_____HAVE YOU EVER BEEN INVOLVED IN A CIVIL SUIT?_____ IF YES, WHEN AND WHY_____

HAVE YOU BEEN INVESTIGATED FOR ABUSE OR NEGLECT?_____IF YES, WHAT WAS THE OUTCOME?

ARE ANY OTHER AGENCIES INVOLVED WITH THE FAMILY? _NO___ IF YES EXPLAIN: _____
_____

DEVELOPMENTAL AND MEDICAL HISTORY OF THE PATIENT:

WHERE DO YOU FALL AMONG YOUR SIBLINGS?

(1ST BORN, 2ND BORN, 3RD BORN, OR ONLY CHILD? Etc.): _____

DID MOTHER HAVE ANY ILLNESS OR COMPLICATIONS DURING PREGNANCY WITH YOU? _____IF YES, _____

PLEASE EXPLAIN: _____

DID MOTHER TAKE ANY DRUGS, MEDICATIONS, ALCOHOL, OR TOBACCO DURING PREGNANCY? _____ IF YES,

PLEASE EXPLAIN: _____

PREGNANCY WAS PLANNED___UNPLANNED____FULL TERM_____PREMATURE ___BIRTH WEIGHT _____

WAS THERE ANYTHING UNUSUAL ABOUT THE DELIVERY? _____ IF YES EXPLAIN: ___

IF YOU HAD ANY PROBLEMS IN ANY OF THE FOLLOWING AREAS OF DEVELOPMENT, PLEASE BRIEFLY DESCRIBE:

SMALL MUSCLE DEVELOPMENT (FINGER/HAND COORDINATION) _____

LARGE MUSCLE DEVELOPMENT (WALKING, RUNNING, JUMPING) _____

SPEECH AND LANGUAGE _____

TOILET TRAINING _____

THINKING AND PROBLEM SOLVING _____

GETTING ALONG WITH OTHER CHILDREN, MAKING FRIENDS _____

SELF-CARE (FEEDING, DRESSING, GROOMING) _____

OTHER _____

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH YOU ARE RECEIVING

TREATMEN_____

LIST ANY KNOW ALLERGIES: _____

LIST ANY MEDICATIONS THE YOU ARE NOW TAKING:

_____

LIST ALL MEMBERS OF THE FAMILY AND OTHERS LIVING IN THE HOME:

NAME	AGE / BIRTHDATE	RELATIONSHIP	GRADE / OCCUPATION

<u>FAMILY HISTORY</u>:

PLEASE CHECK ALL THAT APPLY YOUR FAMILY OF ORIGIN:

	MOTHER	MOTHER'S FAMILY	FATHER	FATHER'S FAMILY
BIRTH DEFECT	_____	_____	_____	
MENTAL RETARDATION	_____	_____	_____	_____
SCHOOL PROBLEMS	_____	_____	_____	_____
LEARNING PROBLEMS	_____	_____	_____	
MENTAL PROBLEMS	_____	_____	_____	_____
EMOTIONAL PROBLEMS	_____	_____	_____	_____
ALLERGIES	_____	_____	_____	_____
EPILEPSY	_____	_____	_____	_____
VISION PROBLEMS	_____	_____	_____	_____
HEARING PROBLEMS	_____	_____	_____	_____

Suicidal behavior	_____	_____	_____	_____
Reckless or Impulsive behavior	_____	_____	_____	_____
ALCOHOL / DRUG ABUSE	_____	_____	_____	_____
MARITAL CONFLICTS	_____	_____	_____	_____

OTHER CONDITIONS OR PROBLEMS:

_____ _____

_____

_____

Revised 09/20/2016