M O V E . B E M O V E D . M O V E O T H E R S .

Intake Form

The following confidential information form is for the use of the therapist only. Complete it as carefully as possible. If the form pertains primarily to a minor, the parents may need to provide most of the answers.

Demographic Information

Name: ____ Today's Date:__________________________

Street Address:____

City:_________________________ State: ____________________ Zip: ______________________________

Home Telephone: ___________________________ Mobile Phone: ___________________________________

Email Address: ____

DOB: ________________ Age:___________ Gender:_____________________________________

Nationality or Ethnicity:____

How did you hear about us?____

Marital Status

___Single ___Married___ (years) ___Divorced ___ (years) ___ Living Together___ (years)

___Separated___ (years) ___Widowed___ (years)

Emergency Contact

Name: _________________________________ Relationship to Client: ____________________

Home Phone: ________________________ Cell Phone: _________________________________

Employment Status

___ Employed Full-time ___ Employed Part-time ___ Unemployed ___ Other:___________________

Occupation:__________________________________ Employer:__________________________________

Education

Highest Level of Education Completed: ___________________ Degree Obtained: ____________________

Spiritual/Religious Preference

___Christian ___ Muslim ___ Jewish ___ Other:____

Intake Form

Current Symptoms/Behaviors

Please mark below, the symptoms which you have experienced in the past 3 months.

___Depression
___Avoiding People
___Feeling hopeless
___ Feeling guilty
___ Obsessions or compulsions
___ Problems getting along with family
___Extreme sadness
___ Feeling Fearful
___Trouble concentrating
___ Problems with anger
___Change in sleeping habits
___ Trouble performing at school/work
___Memory problems
___ Feeling anxious
___Lack of energy
___ Lack of enjoyment of usual activities
___Change in eating habits
___ Acting violently
___Weight changes
___ Feeling tearful or crying spells
___Feeling stressed
___ Muscle tension
___Feeling of extreme happiness
___ Sudden feelings of panic
___Self-esteem problems
___ Physical complaints of pain
___Easily irritated
___ Thoughts of hurting yourself/others
___Change in sexual interest or function
___Difficulty concentrating

Please describe the issue that brought you in today:
____
____
____
____

Any history of abuse (physical, emotional, or sexual):____
____

Medical Information

Primary Doctor Name: ______________________________ Doctor Number: ____________________
Doctor Fax: _________________________________

List all past/current illnesses, injuries or handicaps: ____
____

List any allergies: ____

List any (prescription or over-the-counter) medication that you are currently taking____

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Intake Form

Substance Abuse History

Please list any drugs that you have taken in the past: ____

Is there a history of substance abuse in your family?____

List history of substance abuse treatment:____

Mental Health History

Have you ever been in therapy before? ___Yes ___No If yes, please describe below:

1) Name of therapist:________________________________ Dates___________________________

Type/effectiveness of treatment____

2) Name of therapist_________________________________ Dates___________________________

Type/effectiveness oftreatment____

Previous psychiatric hospitalizations? ____

Previous psychiatric medications?____

Legal Issues

Any custody issues or other legal issues:____

Treatment Information

List three goals you would like to focus on in therapy:

1.____
____

2.____
____

3.____
____

List the three strengths about yourself:

1. ______________________ 2.____________________________ 3.______________________________

Clients Signature/Date: ____

Consent to Treatment
Moss Therapy and Wellness

I acknowledge that I have received, have read (or have had read to me), and understand the professional disclosure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel 24 hours before my scheduled appointment, I will be charged the full fee of my counseling session.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

____	___________________________
Signature of client (or person acting for client)	*Date*
____	___________________________
Printed name	*Relationship to client (if necessary)*

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____	________________________
Signature of therapist	*Date*

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. You will receive a copy of the updated privacy practices if changes are made.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked.. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

____
Signature of client or his or her personal representative

____
Date

____
Printed name of client or personal representative

____
Relationship to the client

____
Signature of authorized representative of this office or practice

____
Date

Debit and Credit Card Payment Authorization

Moss Therapy and Wellness

I am providing my debit or credit card information below for the purpose of paying for my sessions at Moss Therapy and Wellness under the following conditions:

1. My card will be charged the full fee of my counseling session after each missed appointment that I do not cancel with 24 hours notice.
2. My card will be charged when insurance does not cover my sessions, prior to this charge I may opt at any appointment to pay by cash or check in lieu of debit or credit card to pay for charges not covered by insurance.
3. I will receive a transaction receipt by email each time the card is successfully charged.
4. This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

Credit Card Information
Card Type:
___Visa ___MasterCard ___American Express ___Discover

Client Name
Card Number
Back side 3 digits / Front side 4 digit (if AmEx)
Expiration
Zip Code
Email
Client Agreements:

I agree to make payments in cash, by check or debit/credit within 24 hours if a transaction with my card is ever denied. I agree to having my card charged for missed appointments. I agree to having my card charged for appointments I cancel with less than 24 hours notice.

Signature:____ Date:_________________