ADULT INTAKE FORM

Please fill out this form on line or bring it to your first session.

CLIENT INFORMATION:

Name: _____

Address (include city and state): _____

_____

Home Phone: _____ May I leave a message? ☐Yes ☐No

Cell Phone: _____ May I leave a message? ☐Yes ☐No

Work Phone: _____ May I leave a message? ☐Yes ☐No

E-mail address: _____ May I E-mail you? ☐Yes ☐No

*Please note that Email correspondence is not considered to be a confidential form of communication

Date of birth: _____ Age: _____ Gender: _____

Relationship status:

☐Single ☐Living with Someone ☐Married ☐Separated ☐Divorced ☐Widowed ☐ other_____

Emergency Contact/Relation to Client: _____
Provide name and phone number

Who lives at your address? List names and relationship: _____

_____

_____

_____

_____

What do you do during the day/night? Are you self-employed, work for someone else, or are you a stay-at-home parent? Please explain.

_____

_____

_____

MEDICAL AND HEALTH HISTORY

Are you being treated for any mental health or medical diagnosis? If yes, please explain [include name of any medications].

_____

_____

_____

SYMPTOM LIST: PLEASE CHECK ALL THAT APPLY

__depressed mood
__low energy/enthusiasm
__anxiety
__panic attacks; fear
__obsessive thoughts
__intrusive thoughts
__compulsive rituals or behavioral patterns
__engaged in illegal activities
__can't fall asleep
__ending a relationship
__difficulty focusing
__difficulty concentrating
__weight loss
__weight gain
__social isolation
__increase drinking alcohol
__missing work
__missing school
__experienced physical abuse
__experienced mental abuse
__suffering from post-traumatic systems
__have been sexually abused
__family problems
__increase in crying
__perfectionism
__worry a lot/ruminate
__sexual promiscuity
__using illegal drugs/abusing drugs
__recent health problems
__phobias
__recently arrested
__can't stay asleep difficulty staying in relationships
__poor self-esteem
__poor body image
__irritability
__anger management problems
__stress management
__parent/child relationship problems
__issues in primary relationship
__recently separated
__recently divorced
__lost job
__involved with the legal system as a victim
__loss of a love one
__in transition; having trouble making decision
__other_____

Please add anything about your history that you think is significant to understanding yourself today.

Insurance Information

PRIMARY INSURANCE CARD HOLDER

Name: _____ Relation to client: _____

Address if different from client: _____

Phone numbers where you can be reached: _____

Date of Birth: _____ Occupation: _____

Place of Employment: _____

PRIMARY INSURANCE COMPANY

(Please note that sometimes your mental health insurance company is not the same as your medical insurance company. Look on the back of your card for a phone number.)

Name of Company: _____

Insurance Company address and phone number: _____

_____

Member ID #.: _____ Group #: _____

SECONDARY INSURANCE COMPANY INFORMATION

Name of policy holder: _____

Date of Birth: _____ Relation to Client: _____

Address: _____

Name of Company: _____

Member ID #: _____ Group #: _____

Company address and phone number: _____

Amy L. Kopel, LCSW-C, LLC

1107 Kenilworth Dr., Suite 208
Towson, MD 21204
(410) 878-7490

Financial Responsibility and Insurance Release Form

I certify that I, or my dependent(s), have insurance coverage with_____.
I assign directly to Amy L. Kopel, LCSW-C all insurance benefits payable for services rendered. I understand that I am responsible for fees incurred for services not paid by my insurance company, due to my deductible or **failure to call and get authorization prior to the visit (if required)**.

I hereby authorize Amy L. Kopel, LCSW-C to release information to the above mentioned insurance company, and their agents, in an effort to determine insurance benefits and obtaining payments. I authorize the use of my signature on all insurance claim submissions.

I understand that my appointment time is reserved for me and that I will be charged a fee for any appointments missed without 24 hours' notice, except in cases of true emergencies. I understand that if do not return for additional therapy appointments and leave with a missed fee charge, unpaid co-payments or an outstanding balance, Ms. Kopel will charge the amount owed, plus the charge for using the credit card, to the credit or debit card that I provide at the first visit.

_____ _____
Client Signature/Parent/Legal Guardian Date

_____ _____
Client Signature/Parent/Legal Guardian Date

_____ _____
Therapist Signature Date