



CLIENT INTAKE FORM

Please provide the information below for our records. The information provided here will be held to the same standard of privacy and confidentiality as our therapy sessions. Feel free to leave blank any question you prefer not to answer. For your convenience, you can either print this form and bring to our initial session, or arrive thirty minutes early to complete this form in the office.

Name _____ Date of Birth _____
(First, middle initial & last)

Address _____
(include apartment number)

_____ Zip _____
(city & State)

Email Address: _____ is it ok to email you? yes no

Please check "yes" for the telephone number you prefer to receive voicemail messages

yes no Mobile Phone (_____) _____

yes no Home Phone (_____) _____

yes no Work Phone (_____) _____

Emergency Contact

Name _____ Phone (_____) _____

Email _____ Relationship _____

Marital Status

- single partnered married separated divorced widowed

Reason for seeking services at this time:

Previous Therapy: Individual Couple Family Group Inpatient Outpatient
(check all that apply)

Name of Therapist/Clinic _____ Dates _____

Name of Therapist/Clinic _____ Dates _____

Name of Therapist/Clinic _____ Dates _____

For What Issues? _____

Previous Clinical Diagnoses:

Any Previous Psychotropic Medications:

PHYSICAL HEALTH AND HEALTH BEHAVIORS

1. How would you rate your current physical health?	Poor	Below Average	Average	Good	Very Good
<i>Please list any specific physical health problems you are currently experiencing:</i>					
2. How would you rate your current sleeping habits?	Poor	Below Average	Average	Good	Very Good
<i>Please list any specific sleep problems you are currently experiencing:</i>					
3. How would you rate your current eating habits?	Poor	Below Average	Average	Good	Very Good
<i>Please list any difficulties you experience with your appetite or eating patterns:</i>					
4. How many times per week do you generally exercise?	Never	Daily	Weekly	1-2 month	3-4x a year
<i>What types of exercise do you engage?</i>					
4. How often do you drink alcohol?	Never	Daily	Weekly	1-2 month	3-4x a year
5. How often do you engage in recreational drug use?	Never	Daily	Weekly	1-2 month	3-4x a year

EMOTIONAL HEALTH AND WELLNESS

Are you currently experiencing overwhelming sadness, grief or depression?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, for approximately how long?</i>		
Are you currently experiencing anxiety, panic attacks or have any phobias?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, when did you begin experiencing this?</i>		
Have you ever experienced episodes where you could hear things that others around you couldn't hear?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, when did you begin experiencing this? For how long? Currently?</i>		
Are you currently experiencing flashbacks or recurring, intrusive thoughts about a trauma?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, what and when did you begin experiencing this?</i>		
Are you currently experiencing any significant changes in your life?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, what and for approximately how long?</i>		

FAMILY HISTORY

Indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship (father, grandmother, uncle, etc.) to you in the space provided.

Alcohol/Substance Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Post partum Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Eating Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Obsessive Compulsive Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Schizophrenia/Psychosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

PSYCHOSOCIAL HISTORY

1. Are you currently employed? No Yes
If yes, what is your occupation:

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? No Yes
If yes, describe your faith or belief:

Is it important to have religion/spirituality included in your therapy? _____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. How do you currently cope with life stressors

6. Who or what are sources of emotional support?

7. What would you like to accomplish out of your time in therapy?

Tonya Wood, Ph.D.

OFFICE POLICIES & AGREEMENT FOR SERVICES

I am pleased that you have chosen to come to me for professional assistance. To acquaint you with my office policies, the following information is presented so that our work together will be mutually productive and beneficial.

Length of Sessions

Individual, couple and family sessions are for 50 to 60 minutes. Group therapy sessions are 80 to 90 minutes long. Extended session times can be arranged at a proportional additional fee if my schedule permits. Appointments for psychological testing vary in length according to the tests administered. Being prepared to begin each session on time will assure you of receiving the full amount of your allotted time.

Payment of Fees

Payment for services is requested at each meeting unless other arrangements have been made. Our time together can be utilized to the fullest extent if you will have your payment prepared before the session starts. Fees for psychological testing are to be paid in lump sum amounts. Fees for court appearances are paid on a retainer basis. Please understand that checks returned by the bank may not be deposited again and will incur an additional charge.

It is important that questions you have regarding your fees and payment of same be discussed openly so that they will not interfere with the professional service you have sought. Balances, which are not paid, may be turned over to a collection agency. However, I will try to work with you if you are having a financial crisis of some type.

Rescheduling Appointments

The appointment time we have scheduled is reserved exclusively for you. I make every attempt to adhere to a regular day and time so that you may plan your other activities. If a scheduling conflict occurs, it is your responsibility to let me know at least two (2) business days in advance of your appointment. In the absence of sufficient notice, you may be charged for a "failed" appointment. Understandably, emergencies do arise. In such rare instances, every attempt will be made to reschedule your appointment for the same week.

Phone Messages

Should you need to reach me by phone between your scheduled appointments, please leave a message on my voice mail. I check my voice mail regularly on business days and always try to respond as soon as possible, on the same day. In the event of an emergency and you must speak to someone immediately, please go to the local emergency room or 911 if physical harm is at issue.

Unless a phone consultation has been scheduled, telephone conversations should not substitute for your regularly scheduled appointments. If over the course of time I notice that we speak often between sessions, I may recommend that you come in for more than one appointment per week.

The above policies have been developed for our mutual benefit. The intent is to avoid any misunderstanding that might interfere with our professional relationship. Please feel free to discuss any questions or comments you might have with me during our first appointment or at any time in the future.

Your signature below verifies that you have read, understand and agree to these policies.

Client's Signature

Date

Tonya Wood, Ph.D.

LIMITS OF CONFIDENTIALITY

In general, the law protects the confidentiality of all communications between a patient and a psychologist, and I can only release information about our work to others with your written permission. However, there are a number of exceptions.

First, if there is an emergency during our work together where I become concerned about your or your child's personal safety. I will need to share this information with people needed to keep your family safe. If a patient threatens to harm him or herself, I *may* be required to seek hospitalization for the patient and/or to contact family members or others who can help provide protection. These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action. Your son/daughter's safety is my top priority. In addition, if I hear anything about child abuse/neglect or abuse/neglect of an elderly person, I am obligated to report that information to the local authorities.

Second, if I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions, which *may* include notifying the potential victim, notifying the police or seeking appropriate hospitalization for the patient.

Throughout the treatment, I will let you know how your son/daughter is doing and will involve you in his/her treatment as necessary. In order to give your son/daughter some privacy so that he/she feels comfortable talking with me, I will give this information in general terms and not share specific details of situations your son/daughter has described without his or her permission, except in the situations I have already mentioned.

Additional Information Related to Confidentiality:

- I regularly consult with other professionals regarding my patients. In these consultations, the identity of the patient is never revealed. The consultant is, of course, also legally bound to keep the information confidential.
- In most judicial proceedings, you have the right to prevent me from providing any information about your child's treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he or she determines that resolution of the issues demands it. If the court orders me to release information, I am obligated by law to do so.
- If you file a complaint or lawsuit against me, I may disclose relevant information regarding our work in order to defend myself. If you are involved in legal proceedings in which you are claiming emotional suffering, your treatment records may be disclosed in court. Psychologist-patient privilege may not be invoked in effort to hide civil or criminal wrongdoing from the court.
- Disclosure of confidential information may be required by your health insurance carrier in order to process the claims, although only the minimum necessary will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health, disability, or life insurance.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns, which you may have during this session or at any future session. The laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

Your signature below verifies that you have read, understand and agree to these policies.

Patient's/Guardian's signature

Date

Patient's/Guardian's signature

Date