

## Intake Form

Today's Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Please check your preferred contact number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

May I leave a message at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

Education (Last grade completed) \_\_\_\_\_ Degree Earned: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Years of Marriage (most recent): \_\_\_\_\_ Spouse's name: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

### Insurance Information (Please complete the following if you intend to file for insurance):

1. Social Security of Insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2. Insured's Full Name (if same as client, skip to item # 4): \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Patient Relationship to Policy holder: \_\_\_\_\_

3. Insured's Address: \_\_\_\_\_

4. Insured's employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_

5. Insured's Insurance Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Claim Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

6. I authorize the release of medical or any other information to process insurance claims regarding service provided by Sydney Paver, Ph.D.

Signature: \_\_\_\_\_

7. I authorize payment of medical benefits to Sydney Paver, Ph.D.

Signature: \_\_\_\_\_

## Health History

1. Briefly describe your reasons for seeking treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. When did the problem begin and what motivated you to seek treatment now? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. What have you done thus far to improve or alleviate the problem? \_\_\_\_\_  
 \_\_\_\_\_

4. List all past or present mental health treatment:

Dates	Type of treatment	Therapists Name	Where

5. List all current medications: \_\_\_\_\_  
 \_\_\_\_\_

6. List all past psychiatric medications you have taken: \_\_\_\_\_  
 \_\_\_\_\_

7. List any non-prescription drugs (e.g., alcohol, marijuana, cocaine) you currently or periodically use:  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Please place an "X" for any of the following that have ever applied to you:

Medical	Psychological	
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Juvenile delinquency	<input type="checkbox"/> Family problems
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> School phobia	<input type="checkbox"/> Work problems
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> ADHD/hyperactivity	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Running away	<input type="checkbox"/> Binge/compulsive eating
<input type="checkbox"/> Lung problems (e.g., asthma)	<input type="checkbox"/> Truancy	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Incest
<input type="checkbox"/> Cancer	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Rape
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Childhood fears	<input type="checkbox"/> Sexual identity problems
<input type="checkbox"/> Head injury	<input type="checkbox"/> Learning disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> AIDS or HIV+	<input type="checkbox"/> Teenage pregnancy	<input type="checkbox"/> Other _____