CLIENT INTAKE FORM

Client Information:

Name: Last _____ Middle Initial _____ First _____
Title: Mr. ___ Mrs.____ Ms ___ Dr. ___ **Suffix:** Jr. _____ Sr. ____ First ____ Second ____ Third ____
Sex: Male ___ Female ___ **D.O.B.:** _____ **Age:** ____ **Social Security #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:**_____
Phone: (Home) _____ (Cell) _____ (Other) _____
Email (optional): _____ May we contact you via email? Yes _____ No _____
Relationship Status: Married ___ Divorced ___ Single___ In Relationship ___ Widowed ___ Separated ____
Employer: _____ **Job Title:** _____
Occupation: _____ **Circle One:** Full-time / Part-time / Student / Retired / Unemployed

Emergency Contact: Name _____ Phone _____ Relationship _____
Please fill out the following information if another party is financially responsible for all professional services rendered to you at this office:
Name of Organization: _____ Phone: _____
Individual's Name: Last _____ Middle Initial _____ First _____
Address: _____ City _____ State _____ Zip _____
How did you hear about our office? Work ( ) EAP ( ) Friend ( ) Dr. ( ) Psychiatrist ( ) Hospital ( )
Primary Care Physician / Medical Information: Do we have permission to contact your physician? Y ___ N ___
Name of Physician: _____ Phone: _____
Address: _____ City _____ State _____ Zip _____
Psychiatrist: Do we have permission to contact your psychiatrist? Y ___ N ___
Name of Psychiatrist: _____ Phone: _____
Address: _____ City _____ State _____ Zip _____
By signing below, you authorize this office to contact your physician and/or your psychiatrist (as indicated above), and to inform your doctor and/or psychiatrist of your mental health therapy.
Client Signature: _____ Date: _____
Witness Signature: _____ Date: _____

List any medications you are currently taking:
Name: _____ Generic?: ____ Date began:_____ Purpose: _____
Name: _____ Generic?: ____ Date began:_____ Purpose: _____
Name: _____ Generic?: ____ Date began:_____ Purpose: _____

List any past medications:
Name: _____ Generic?: ____ Date began:_____ Purpose: _____
Name: _____ Generic?: ____ Date began:_____ Purpose: _____
Are you allergic to any medications? Y ___ N ___ If yes, list them here:_____
Medical conditions you are currently being treated for: _____
_____

Insurance Policy Holder Information:
Primary Insurance Company: _____ Phone: _____
Address: _____ City _____ State _____ Zip _____
Policy Holder Name: _____ Policy Holder D.O.B.: _____
Social Security #: _____ Sex: M ( ) F ( ) Insured relationship to client: _____
Policy Holder Phone: _____ Employer: _____
Group #: _____ Individual Policy #: _____

Secondary Insurance Company: _____ Phone: _____
Address: _____ City _____ State _____ Zip _____
Policy Holder Name: _____ Policy Holder D.O.B.: _____
Social Security #: _____ Sex: M ( ) F ( ) Insured relationship to client: _____
Policy Holder Phone: _____ Employer: _____
Group #: _____ Individual Policy #: _____

Client Last Name First Name Date

Feelings:	A Little	A Lot	Comments
Sad			
Anxious			
Stressed			
Scared			
Lonely			
Guilty			
Frustrated			
Angry			
Degraded			
Problems:			
At Home			
At School			
At Work			
In my Social Arena			
Sleeping			
Eating			
Weight Gain			
Weight Loss			
Harm to Self/Others:			
I have hurt someone in the past			
I have thoughts of hurting someone			
I have thoughts of hurting myself			
Support:			
I have close friends to talk to			
I have family that is there for me			
Self Worth:			
I feel confident in my abilities to solve problems			
I feel good about myself			

List areas of concern (in order of priority):

1. _____
2. _____
3. _____

What dates have you previously been in counseling, and for how long?

_____

_____

_____

FOR OFFICE USE ONLY

First session date: _____

DSM-IV Diagnosis: Axis I: _____ Code: _____

Axis II: _____ Code: _____

Kopp's Counseling

4237 Salisbury Road, Building 3, Suite 302 Jacksonville, Florida 32216 ● ☎(904) 923-3605 ● help@koppscounseling.com

ACKNOWLEDGEMENT OF RECEIPT OF KOPP'S COUNSELING – NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Kopp's Counseling – Notice of Privacy Practices. I understand that the privacy practices described in this notice are effective as of February 22, 2013.

Participant's Name (print) _____

Participant's or Guardian's Signature: _____

Signature Date: _____

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MISSED SESSION / CANCELLATION FEE POLICY

AS OF 06/01/15

If you miss your appointment, or cancel your appointment, with less than 24-hour notice, you will be charged $85.00. This fee is not billable to your insurance company. You, the patient, will be personally responsible for paying this fee at, or prior to, the next scheduled session. If do not schedule another session, an invoice will be mailed to your address on file, and it must be paid within 30 calendar days. **If you incur multiple fees, and/or the fees remain unpaid for 30 days or more, it may prevent you from scheduling a future session, at the discretion of the therapist.**

This fee will be applicable regardless of the reason for missing a session, including but not limited to: forgetting the appointment, work-related matters, scheduling conflic , family issues, personal difficulties, transportation problems, and/or sickness, etc.
Special considerations may be made in extreme circumstances (such as an accident, serious illness, or hospitalization), but we may require you to provide documentation to support y ur claim.

This policy is in place out of respect for all of our clients. Cancellations with less than 24-hour notice are difficult to fill, and by giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and accept the Missed Session / Cancellation Policy for Kopp's Counseling as described above.

Thank you for your understanding and cooperation.

_____
Printed Name

_____
Signature

_____
Date