Dr. Sally Diane, LMFT

Licensed Marriage and Family Therapist

PO BOX 6055

La Quinta, Ca. 92248-6055

(760) 777-1577

(760) 777-1557 fax

INTAKE FORM

Personal Information

Name: ______________________________ Date: ____________

Parent/Legal Guardian (if under 18): ______________________________

Address: ______________________________

Home Phone: ___ ____________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: ____________________ May we leave a message? □ Yes □ No

Email: ____________________ May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: ____________________ Age: _______ Gender: ____________

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any): ______________________________

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: ____________________

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list:

____

____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

____

____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: ____________________

____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

____

3. How many times per week do you generally exercise? ____________________
What types of exercise do you participate in? ____________________

4. Please list any difficulties you experience with your appetite or eating problems: ____________________

____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?____________________

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____________________

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ____________________

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

____

11. What significant life changes or stressful events have you experienced recently? ____________________

____

____

Family Mental Health History

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

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	________
Anxiety	yes / no	________
Depression	yes / no	________
Domestic Violence	yes / no	________
Eating Disorders	yes / no	________
Obesity	yes / no	________
Obsessive Compulsive Behavior	yes / no	________
Schizophrenia	yes / no	________
Suicide Attempts	yes / no	________

Additional Information

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation? ____________________

____

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: ____________________

____

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

____

____

____

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

____

____

____

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

____

____

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client

A $25.00 fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. * Insurance cannot be billed for a missed appointment.
Thank you for your consideration regarding this important matter.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date

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MEDICAL INSURANCE VERIFICATION FORM

PATIENT NAME:____

PATIENT ADDRESS:____

CITY, STATE & ZIP____

SEX: MALE______FEMALE______ DATE OF BIRTH__________________

SSN_____________________________TELEPHONE__________________

PATIENT STATUS (check what applies): SINGLE______MARRIED______OTHER:______

EMPLOYED______STUDENT______RETIRED______ OTHER ______________

PATIENT RELATIONSHIP TO INSURED:____________________________

INSURED'S NAME:_________________________________SEX: M F

ADDRESS:____

CITY, STATE & ZIP:____

INSURED'S DATE OF BIRTH________________TELEPHONE_____________

INSURANCE COMPANY NAME:____________________________________

ADDRESS:____

CITY, STATE & ZIP:______________________INSURANCE PHONE______________

INSURED'S I.D. NUMBER:_____________________________________

INDURED'S POLICY#, GROUP# OR FECA NUMBER:___________________

EMPLOYER'S NAME OR SCHOOL__________________________________

HAVE YOU CALLED YOUR INSURANCE COMPANY TO OBTAIN AUTHORIZATION (IF NECESSARY?) YES____ NO____ AUTHORIZATION# ______________________

IS THERE ANOTHER HEALTH BENEFIT PLAN?:______________________

PATIENTS SIGNATURE:____

*PLEASE PROVIDE INSURANCE CARD FOR COPY TO BE MADE. THANK YOU.

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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, ~~American Express~~ and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Client Information:

Client name:________________________________Date of birth:____________________

Cardholder Information:

Please indicate the name as appears on card and *address associated with the card you wish to use.*

Name:__________________________________Phone:__________________________

Address:_______________________City:____________State:________Zip:__________

Cardholder relationship to client : ____

Credit/Debit Card Information:

Please provide your payment information below.

Card Type (circle one) Visa MasterCard Discover

Card number:____

Expiration Date:______/________CVV Code (last 3 digits on back of card):______________
mo yr

I authorize any service fees to be deducted from the credit or debit card ending in:______________ (please provide the last 4 digits of the card).

_______________________________________ ____________________
Cardholder Signature **Date**