Serenity Mental and Medical Health Care

"Because you are alive, everything is possible."
— Thich Nhat Hanh

INTAKE FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started, we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE | **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | **Group Number**

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SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist? ☐ YES ☐ NO

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past? ☐ YES ☐ NO

If yes, when and by whom?

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Please List any medication you have taken or are taking:

Medication and Dosage	Date	Side Effects/Benefits

Please Check all that apply:

☐ Depressed mood	☐ Excessive talking	☐ Unreasonable fear
☐ Lost or gained weight	☐ Racing thoughts	☐ Fear of social situations
☐ Not enough sleep	☐ Easily distracted	☐ Repetitive thoughts/behavior
☐ Too much sleep	☐ Over working yourself	☐ Upsetting memories
☐ Sluggish	☐ Impulsive behavior	☐ Recent loss/grief
☐ Agitated	☐ See/hear things that are not real	☐ Work/school problems
☐ Never tired	☐ Suspect things may not be real	☐ Violent thoughts/behaviors
☐ Cannot concentrate	☐ Tense/unable to relax	☐ Self harm
☐ Afraid to leave home	☐ Excessive worry	☐ Anger outburst
☐ Inflated self esteem	☐ Panic attacks	☐ Careless, high-risk behavior
☐ Feel guilty or worthless	☐ Thoughts of death or suicide	☐ Financial problems

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GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have below:

_____

_____

_____

_____

_____

Please list any serious medical procedures you have had in the past:

_____

_____

_____

_____

_____

Are you on any medications for any general medical problems you may have? ☐ **YES** ☐ **NO**

If yes, which ones? _____

Do you have any allergies to medications? ☐ **YES** ☐ **NO**

If yes, which ones? _____

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Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side **Father's side**

SOCIAL HISTORY

Birth place: Where did you grow up?

Did your parents get divorced as a child? ☐ **YES** ☐ **NO**

If so, how old were you when they separated?

Father's occupation growing up:

Mother's occupation growing up:

How many siblings do you have?

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Did you have any early development problems as a child?

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Highest Level of Education:

Current employment:

Are you currently in a romantic relationship? ☐ **YES** ☐ **NO** Duration: _____

Describe your relationship:

Spouse or partner's current occupation:

Do you have any children? ☐ **YES** ☐ **NO** How many? _____

What are your children's names and ages?

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What activities do you enjoy doing?

Have you ever been convicted of any crimes, served time, or been on probation? ☐ YES ☐ NO

Details:

Are you currently involved in a court case to determine custody of your children? ___YES ___NO

Please list any additional notes that you think would be helpful for treatment below:

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LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name _____ Last Name _____

Release of Information: I, the subscriber named below, authorize Serenity Mental and Medical Health Care/Harmony Within and any therapists working under Serenity Mental and Medical Health Care/ Harmony Within treating me to release any and all information pertainingto my treatment to any third-party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Medicare/Medicaid – Client's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the therapist treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE THERAPIST'S OFFICE. This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the client for fees paid to the therapist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

Patient Name (please print) _____

Patient/Guardian Signature _____ Date _____

Insurance Company _____

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APPOINTMENT CANCELLATION AGREEMENT

First Name _____ Last Name _____

Each meeting is another opportunity to help you confidently take charge and start living the life that's important to you. We understand things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, the office of Serenity Mental and Medical Health Care requires **24 business hours notification (Monday through Friday 8:00 am to 5:00 pm).** Please understand that we set aside this time for you, and if you are unable to make it, we will have missed an opportunity to meet with another valuable client. This policy is in place to give the office enough time to schedule another client in that time slot. If you fail to cancel within 24 hours prior to your appointment **a $75 fee will be charged to the card below** or the credit card on file.

While we do call to remind you of your appointment, it is your responsibility to call the office at 910-637-0051 to cancel.

I authorize the following card to be used for co-pays and fees incurred during the time I am a patient with Serenity Mental and Medical Health Care/Harmony Within .

Card Number _____

Expires _____ Billing Zip Code _____ CVV _____

Printed Name _____

Signature _____ Date _____

I understand that the office of Serenity Mental and Medical Health Care/Harmony Within will attempt to bill my insurance, however **if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency, I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print) _____

Patient/Guardian Signature _____ Date _____