

# INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Domestic Partnership  Married  Separated

Divorced  Widowed

Please list any children/age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) May we leave a message?  Yes  No

Cell/Other Phone: ( ) May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

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

Referred by (if any): \_\_\_\_\_

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

Please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates: \_\_\_\_\_

\_\_\_\_\_

#### GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

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)

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 patterns

\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic 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 recreational drug use?  Daily  Weekly  Monthly  
 Infrequently  Never

10. Are you currently in a committed relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10, 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 (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:

\_\_\_\_\_

## Current Concerns

Please fill in circles:

### AMOUNT

	Low	Moderate	Severe
<b>I am experiencing:</b>			
Sadness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety/Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anger/temper problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reasoning/Judgment Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentration Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memory Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Energy Level Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**EDWARD G. HOCHSTEIN, M.S., LMFT.**

Licensed Individual, Couple & Family Psychotherapy

806 Hawthorn Ave., Suite A  
Boulder, Colorado 80304  
303.449.9425 Fax: 303.440.0960

**FOR YOUR INFORMATION**

The practice of psychotherapy is regulated by the Dept. of Regulatory Agencies. The address and telephone number of the grievance board are: 1560 Broadway, Suite 1370, Denver, Colorado, 80202; 303.894.7766.

You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time (except under special circumstances).

In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board.

The information provided by a client during therapy sessions is private and legally confidential, except for certain legal exceptions which will be identified should any such situation arise during therapy.

In addition, you are informed that **should you elect to utilize your insurance coverage, all records may be shared** with your insurer, especially to justify continued “medically necessary” treatment beyond the limited number of sessions initially authorized by them.

You are entitled to be informed of your therapist’s degrees and credentials.

I have read the preceding information and understand my rights as a client.

\_\_\_\_\_  
Client Signature (or parent/guardian)

\_\_\_\_\_  
Date

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**POLICY STATEMENT**

**Fee Schedule :**

A. Private Pay:

Office appointments are charged at the rate of \$95 for each 50 minutes.

B. Insurance:

If you elect to utilize insurance, you are responsible for your CO-PAY and/or any deductible amounts.

C. All clients:

After hours phone calls, and third party consultations including reports, are charged at the rate of \$95 for each 50 minutes, or prorated accordingly. **There is a \$25 minimum charge for these services.**

**Payment Policy:**

**Payment is due in full at the end of each session.** If you elect to utilize insurance, **co-pays** are due in full at the end of each session.

D. Please only use **Email** for **non-clinical, administrative** purposes.

**CANCELLATIONS:**

**LATE CANCELLATIONS (LESS THAN 24 hours) and MISSED APPOINTMENTS ARE CHARGED MY REGULAR OFFICE RATE OF \$95, except for emergencies.**

\_\_\_\_\_  
Please Initial

**EMERGENCIES:**

- A. Clients are assumed to be self-responsible (i.e., autonomous, functioning, and not in need of day-to-day supervision, etc.).
- B. Practitioner cannot assume responsibility for client’s day-to-day functioning as can institutions (agencies, inpatient hospital settings, etc.).
- C. Client must discuss any expectations of After-Hours care with Practitioner upon intake so that if necessary, and with exceptions, appropriate referral can be made. I am available by voice mail until 9:30 P.M. daily for non-emergency and emergency contact.
- D. Options for emergency/crisis support After-Hours include:
  - 1. Your managed care/insurance company (Crisis Line) as appropriate
  - 2. The Boulder County Mental Health Center Emergency/Crisis Dept.
  - 3. Your local hospital emergency room.
  - 4. Police and Sheriff Departments at **911**

**CLIENT AGREEMENT / CONTRACT:**

- 1. Client agrees to and understands all professional policies.
- 2. Client agrees to meet all financial obligations.
- 3. Client understands that **UNPAID ACCOUNTS TWO MONTHS IN ARREARS WILL BE REFERRED TO A COLLECTION AGENCY.**

\_\_\_\_\_  
Client Signature (or parent/guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Date