BARBRA ROGOFF, LCSW

Psychotherapist

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CLIENT INTAKE FORM

Welcome! In order to better identify your needs and develop a plan for your treatment, please take a few moments to complete the following form.

NOTE: All information will be kept in a secure location and none of your information will be shared with anyone without your written consent pursuant to Notice of Privacy Practices.

Date: _____

Name: _____ Social Security No: _____

Date of Birth: _____ M ☐ F ☐ Marital Status: _____

Physical Address: _____

Mailing Address
(if different) _____

Home Phone: _____ Other Phone/Type: _____
OK TO LEAVE MESSAGE Y ☐ N ☐ OK TO LEAVE MESSAGE Y ☐ N ☐

Email Address: _____

Occupation: _____ Employer Name: _____

Ethnicity: _____ Sexual Orientation: _____

Religious Affiliation: _____ Gender Identity: _____

Primary Care Physician: _____ Phone Number: _____

Date of last appointment: _____ Date of last physical: _____

Psychiatrist: _____ Phone Number: _____

Date of last appointment: _____

Referred by or where you heard about me: _____

Emergency Contact: I require that you give me contact information for a person I can contact in case of an emergency. This contact will only be used if I believe you or someone else is in immediate danger or if you become ill and are unable to continue or depart therapy without assistance.

Emergency Contact's Name: _____

Relationship: _____ Phone Number: _____

Please initial your agreement for me to contact the above named person under the above named conditions _____

Please complete the following if you will be using insurance for your psychotherapy sessions.

Primary Insurance Information

Insurance Company: _____

Identification #: _____ Group #: _____

Provider Services Phone #: _____

Insurance Company Address (on back of card): _____

Policy Holder Name: (if different then client) _____ DOB: _____

Social Security #: _____ Employer: _____

Relationship to Client: _____ Phone Number: _____

Mental Health Plan (if different): _____

Identification #: _____ Group #: _____

Provider Services Phone #: _____

Insurance Company Address (on back of card): _____

Secondary Insurance Information

Insurance Company: _____

Identification #: _____ Group #: _____

Provider Services Phone #: _____ _____

Policy Holder Name: (if different then client) _____ DOB: _____

Social Security #: _____ Employer: _____

Relationship to Client: _____ Phone Number: _____

Have you ever been diagnosed with a mental illness: Y☐ N☐ If yes, please list: _____

_____

Have you ever received mental health treatment (therapy, psychiatry, medication, hospitalization) before? If so, please list dates, providers, and reasons for treatment:

_____

_____

_____

_____

Please list any medical conditions: _____

_____

_____

_____

_____

_____

Please list all of your current medications (including dosage and frequency):

Please list any allergies to medication:

Please list other people living in your household and their relationship to you:

Please describe your reason(s) for seeking treatment at this time. Please identify any significant events which contributed to your decision to seek treatment now.

How are you hoping treatment can help you? If you were doing "better", what would that look like?

Please indicate all that you are experiencing difficulty with and rate the extent of difficulty on a scale of 1 to 10, with 1 being mild and 10 being significant.

	Yes/No	Rating		Yes/No	Rating
Relationships			Obsessive Thoughts		
Family			Suicidal Thoughts		
Job / School			Homicidal Thoughts		
Friendships			Hallucinations		
Finances			Please specify:		
Physical Health			Delusions		
Anxiety			Please specify:		
Depression			Intrusive Thoughts		
Grief / Loss			Impulsivity		
Mood Instability			ADHD / ADD		
Hopeless / Helpless			Physical Abuse		
BiPolar Disorder			Sexual Abuse		
Anger / Frustration			Drugs / Alcohol		
Fear / Phobias			Legal Problems		
Other:					

Is there anything else you believe I need to know now to better help you?