INTAKE FORM - CENTRAL PSYCH CHARLOTTE

Name:_____ *Goes by* (_____)

Male ☐ Female ☐

Today's Date:___/____/_____

Birthdate:_____/_____/_____ Age _____

Address: _____City, state, zip code: _____

Preferred phone number: _____

May we leave messages on your phone and email? Please circle Yes or No

Emergency Contact: (name and phone number) _____

Employer/Occupation: _____ E-mail:_____

Who referred you to us? _____ May we let them know you came? Yes ☐ No ☐

Family Information:

Married	Living together	Single	Separated	Divorced	Widowed

Description of Present Difficulties:

Please briefly describe the problem(s) that you want to talk about in therapy:

- Have you been in counseling before? Yes ☐ No ☐
- What was the main focus?

Note any significant medical history:

Please list any medications you are taking or have taken within the last 6 months:

Religious Beliefs:

If you think your religious beliefs could be a factor in either the problem or helping with your therapy, please provide a brief explanation

Consent for Treatment

- I acknowledge that I have access to, have read (or have had read to me) and understand the *Limits of Confidentiality* and/or other information about the therapy I am considering.
- I do hereby seek and consent to take part in a consultation and/or treatment with a clinician associated with Central Psych Charlotte.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.
- **I know that I must call a minimum of 24 hours before an appointment time, or if I miss, there will be a charge.**
- I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I authorize the release of any medical or other information necessary to process a claim.

- I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.
- I understand that whatever I say will be kept in confidence with the exception of the conditions mentioned in the *Limits of Confidentiality*.
- I understand that Central Psych Charlotte cannot guarantee the absolute confidentiality of fax, cell phone and email communications because of technological limitations. Should I or Central Psych Charlotte elect to communicate via these means, I accept these limitations.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or responsible party)	Date	Relationship to client
_____	_____	_____