REGISTRATION AND INTAKE FORM

CLIENT CONTACT INFORMATION

_____ _____ _____
Last Name First Name Social Security #

Address_____ City_____ State_____ Zip_____

Please check below if a message can be left at the following numbers
_____ Home phone: (_____)_____ _____ Work phone: (_____)_____
_____ Cell phone: (_____)_____ Cell phone carrier: _____
Email address:_____

APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)
___ Via text message on my cell phone (normal text message rates will apply according to your contract)
___ Via email message to the address listed above
___ Via automated telephone message to my home phone
___ None of the above. I'll remember my appointments on my own

Signature:_____ Date:_____

CLIENT PROFILE INFORMATION

Date of Birth_____ Male____ Female____ Marital Status: Single___ Married____ Other____

Household Member Name Date of birth Relationship to you

_____
_____
_____
_____

Emergency contact:_____
Name Phone number Relationship

BILLING INFORMATION

Responsible Party Name (who pays the bill):_____ SSN:_____

Responsible Party Address: _____
Street City State Zip Code

Primary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

Secondary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

REFERRAL INFORMATION

How did you find out about Perspectives Therapy Services? Check appropriate box

□ Friend(s)/Neighbors □ Family Member □ Physician/Family Doctor □ Web-search/internet
□ Social Service Agency □ Court System □ School System □ Yellow Pages
□ Other (please specify)_____

May we send a general thank-you to this referring source? □ Yes □ No
If yes, where should this be sent? _____

PREVIOUS THERAPY EXPERIENCE

Have you received mental health services (counseling/therapy) in the past? _____Yes _____No
If yes,……..When?_____Where or with whom?_____
For what reason?_____

What was *most* helpful about this therapy experience?_____
_____

What was *least* helpful about this previous therapy experience?_____
_____

MEDICAL BACKGROUND

Primary Care Physician_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Please list any medications you are taking at this time.

Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking

Have you ever been hospitalized for reasons relevant to your attending therapy? □ Yes □ No
If yes, please describe_____

PROBLEM SPECIFICATION

Briefly describe what brings you to therapy at this time_____
_____

What would you like to see happen as a result of therapy? _____
_____

Office Use Only

Therapist initials:_____ Location: B L H Diagnosis code:_____ Supervisor:_____
USERNAME: PASSWORD:

Thank you for providing the information requested on this form. This is considered confidential information and will not be shared with anyone other than your therapist unless permission is granted through written consent.