WELCOME TO FOUNTAINGATE

Psychological and Family Services
1106 Columbia Ave, Suite 100
Marysville, WA 98270
Phone: 360-653-0374 Fax: 360-658-0219

INDIVIDUAL INTAKE

YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE WILL BE HELPFUL IN PLANNING OUR SERVICES FOR YOU. PLEASE ANSWER EACH ITEM CAREFULLY OR ASK FOR CLARIFICATION IF YOU DO NOT UNDERSTAND AN ITEM.

NAME:_____ TODAY'S DATE:_____
First MI Last

PHYSICAL ADDRESS:_____
STREET NUMBER

_____
CITY STATE ZIP

MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS:_____
PO BOX OR STREET NUMBER

_____
CITY STATE ZIP

HOME #:_____ CELL:_____ WORK:_____

AGE:_____ BIRTHDATE:_____ SSN:_____ DRIVERS LICENCES#:_____

MARITAL STATUS (CIRCLE ONE): MARRIED DIVORCED SINGLE SEPERATED OTHER:_____

EMPLOYER:_____ OCCUPATION:_____

YEARS EMPLOYED:_____ EDUCATION:_____

REFERRED BY:_____ PHONE:_____

PERSON NOT LIVING WITH YOU TO CONTACT IN AN EMERGENCY:

_____
NAME RELATIONSHIP PHONE

TO BE COMPLETED BY THERAPIST

PRIMARY DIAGNOSIS:_____ SECONDARY DIAGNOSIS:_____ TERTIARY DIAGNOSIS:_____

TREATMENT AGREEMENT:

PLEASE INITIAL:

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. _____

I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO FOUNTAINGATE. WHILE FOUNTAINGATE WILL BILL MY INSURANCE COMPANY, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED IF MY INSURANCE COMPANY DOES NOT PAY. _____

IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO OBTAIN THE PROPER AUTHORIZATIONS IF REQUIRED. IF I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES. _____

IF YOUR PORTION OF THE BILL IS OVER 90 DAYS OLD YOU WILL BE SENT TO COLLECTIONS, UNLESS OTHER ARRANGEMENTS ARE MADE WITH OUR BILLING OFFICE. _____

ARE FEES ARE AS FOLLOWS $200.00 FOR INTIAL SESSION, INDIVDUAL SESSIONS ARE $150.00, FAMILY/MARITAL SESSIONS ARE $175.00, FAMILY SESSIONS (PATIENT NOT PRESENT) ARE $185.00, AND GROUP SESSIONS ARE $60.00. _____

YOU WILL BE CHARGED $150.00 FOR MISSING AN APPOINTMENT WITHOUT CANCELLATION NOTICE. _____

YOU WILL BE CHARGED $150.00 FOR NOT GIVING 24 HOURS NOTICE, WHEN CANCELING AN APPOINTMENT. _____

I HAVE READ THROUGH THE TREATMENT AGREEMENT THOROUGHLY AND UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

CLIENT SIGNATURE:_____ **DATE**:_____

TO ENABLE OUR STAFF WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

PLEASE BE AWARE THAT EMAIL AND FAX TRANSMISSIONS ARRIVE AT A GENERAL FOUNTAINGATE SITE AND ARE DISTRIBUTED TO THE INDIVIDUAL PRACTITIONER CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN OUR OFFICE.

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY ANSWERING MACHINE.

_____YES _____NO

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS**:**

_____

_____

THE FOLLOWING INDIVIDUALS MAY DISCUSS MY ACCOUNT WITH THE BILLING DEPARTMENT:

_____

(INTENTIONALLY LEFT BLANK)

CONCERNS AND GOALS:

PLEASE DESCRIBE WHY YOU HAVE COME IN:_____

_____

DESCRIBE GOALS YOU WANT TO ACCOMPLISH BY COMING HERE:_____

_____

_____

PLEASE **CIRCLE** INDIVIDUAL ITEMS YOU WANT TO ADDRESS. PLEASE **UNDERLINE** THE **TWO MOST IMPORTANT**, TO ADDRESS FIRST:

CONCENTRATION	FEARS	BOWEL TROUBLE	SELF-ESTEEM
HOPELESSNESS	GUILT	STOMACH TROUBLE	TEMPER
DEPRESSED	SELF-CONTROL	SEXUAL PROBLEM	RELAXATION
HARM TO SELF	HARM TO OTHERS	DRUG USE	FINANCES
SUICIDAL CONCERNS	IMPULSIVITY	ALCOHOL USE	WORK
HIGH ENERGY	HYPERACTIVE	HEADACHES	MOTIVATION
LOW ENERGY	ATTENTION DIFFICULTIES	MEMORY	LEGAL MATTERS
ANGER	SLEEP PROBLEMS	THOUGHTS	CAREER CHOICES
TEMPER	DREAMS	ABUSE	EDUCATION
NERVOUSNESS	NIGHTMARES	TRAUMA	MAKING DECISIONS
ANXIETY	HEALTH PROBLEMS	SHYNESS	MEANINGLESSNESS
STRESS	APPETITE/WEIGHT	CRYING SPELLS	UNRESOLVED GRIEF
PANIC	EATING/FOOD TROUBLE	UNHAPPINESS	SPIRITUAL CONCERNS

PLEASE **CHECK** RELATIONSHIP ITEMS YOU WANT TO ADDRESS. **UNDERLINE** THOSE YOU FEEL APPLY TO ANOTHER FAMILY MEMBER. PLEASE **CIRCLE** THE **TWO MOST IMPORTANT** TO ADDRESS FIRST.

MARRIAGE	PARENTING	RECREATION	FRIENDSHIPS
SEPARATION	CHILDREN	INFIDELITY/AFFAIRS	HOLDING OTHER DOWN
DIVORCE	HOUSING	PHYSICAL FIGHTING	CONFLICTING SCHEDULES
INTIMACY	FINANCES	COMMON INTERESTS	PROBLEM SOLVING
IN-LAWS	SEXUAL DESIRE	SHOWING APPRECIATION	LONELINESS
RELATIVES	AGREEING ON CHORES	TRUSTING EACH OTHER	COMMON GOALS
JEALOUSY	SEXUAL PERFORMANCE	AFFECTION	VERBAL FIGHTING
USE OF TIME	SPOUSE'S CLEANLINESS	COMMUNICATION	HAVING FUN TOGETHER

HEALTH INFORMATION:

LIST ALL CURRENT MEDICATIONS:_____

_____

LIST ALL CURRENT HEALTH PROBLEMS:_____

_____

LIST PAST SIGNIFICANT HEALTH PROBLEMS:_____

_____

HAVE YOU BEEN HOSPITALIZED OR HAD OTHER PSYCHIATRIC CARE RELATED TO YOUR MENTAL HEALTH? **YES** **NO**

IF YOU ANSWERED YES PLEASE PROVIDE DATES AND TREATMENT OUTCOME FOR THOSE EVENTS:_____

_____

LIST PREVIOUS PROFESSIONAL HELP YOU HAVE RECEIVED FOR PERSONAL, MARITAL, OR FAMILY CONCERNS AND DATES:

_____

NAME OF YOUR PRIMARY CARE PHYSICIAN:_____ MAY WE CONTACT? **YES** **NO**

PHONE NUMBER:_____WHEN WERE YOU LAST SEEN?_____

DRUG AND ACHOHOL ASSESSMENT:

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office?
_____Yes _____No If yes _____self _____other: Relationship_____

ALCOHOL ASSESSMENT:

Alcohol frequency:
___ Never ___ Less than1 time/month ___ 1-4 times per month ___ 2-3 times per week ___ Daily

Usual Alcohol Consumption:
___ None ___ 1-2 drinks per sitting ___3-4 drinks per sitting ___ 5 or more drinks per sitting

Intoxication Frequency:
___ never ___ less than 1 time/month ___ 1-4 times per month ___ 2-3 times per week ___ Daily

Please describe any alcohol-related problems (e.g. legal, job, physical, or social):_____

_____

Self-perception of **Alcohol Use**: (please check)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___ Attended AA/ other 12 step program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

OTHER SUBSTANCE USE ASSESSMENT: (Check Frequency and Duration for each drug used in the last 6 months)

	Frequency			**Duration**	
	Daily	Weekly	Monthly Or less	Less than one year	More than one Year
Marijuana	_____	_____	_____	_____	_____
Sedative	_____	_____	_____	_____	_____
Stimulant	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Opiates	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____	_____
Prescription Drugs	_____	_____	_____	_____	_____

Caffeine _____ Number of cups per day _____ Tobacco____ if cigarettes-number per day _____

Please describe any drug-related problems (e.g. legal, job, physical, or social):_____

_____

Self-perception of **Drug Use**: (please check)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___ Attended NA/ other program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

LEGAL INFORMATION:

DO YOU HAVE A PROBATION OFFICER OR CASE WORKER? **YES NO** MAY WE CONTACT THEM? **YES NO**

WHAT IS HIS/HER NAME?_____

PHONE NUMBER:_____ADDRESS:_____

DO YOU HAVE AN ATTORNEY? **YES NO** IF YES, WHAT IS HIS/HER NAME?_____

PHONE NUMBER:_____ ADDRESS:_____

MARITAL INFORMATION:

MARRIED: _____ DIVORCED: _____ LIVING TOGETHER: _____ SEPARATED: _____ SINGLE: _____ OTHER: _____

IF YOU CHECKED "OTHER" PLEASE EXPLAIN:_____

_____

LIST DATES AND LENGTHS OF ANY PREVIOUS MARRIAGES:_____

_____

FAMILY HISTORY:

LIST THE NAMES, AGES, AND RELATIONSHIP, OF ALL PERSONS LIVING IN YOUR HOME:

_____

_____

_____

LIST THE NAMES, AND AGES OF ANY IMMEDIATE FAMILY MEMBERS THAT ARE NOT LISTED ABOVE

_____

_____

_____

_____

RELIGOUS HISTORY:

ARE SPIRITUAL OR RELIGOUS ISSUES A CONCERN TO YOU _____YES _____NO

WHAT IS YOUR RELIGIOUS AFFILIATION, IF ANY?_____

IF YES, WHAT IS THE NAME OF THE CONGREGATION YOU BELONG TO?_____