Lisa McSweeney Counseling

Intake Information

For Office Use Only
Dx_____
_____
_____
Date of first session
_____

Personal Data

Please complete as fully as possible
Use Only

Patient Name_____
Dx_____

Address_____

City_____ State_____ Zip Code_____

Phone at home (_____)_____ Cell Phone (_____)_____

E-mail_____

Birthdate___-___-___ Female ☐ Male ☐ Single ☐ Married ☐ Widowed ☐ Separated

S.S.N._____ Employer_____ Occupation_____

Primary Care Doctor_____ Phone_____

Referred by_____ Phone_____

Emergency Contact_____ Phone_____

If another person is responsible for charges

Name_____Phone at home(_____)_____

Address_____ Phone at work (_____)_____

Primary Insurance_____
Subscriber_____

Group#_____ Identification #_____ Patient's relation to subscriber is:

Employer_____ self ☐ spouse ☐ child ☐ other

Secondary Insurance_____
Subscriber_____

Group#_____ Identification #_____ Patient's relation to subscriber is:

Employer_____ self ☐ spouse ☐ child ☐ other

Consent for treatment, statement of financial responsibility, and release of information

I hereby give my consent for psychiatric and psychological consultation and treatment.
I understand that each psychiatrist/psychologist in this office is an independent practitioner and no other clinician is involved in the consultation and/or treatment of me or my dependent.
I agree to be financially responsible for all charges that accrue from consultation and treatment.
I agree to be financially responsible for cancelled appointments in accord with my doctor's cancellation policy.
I authorize insurance benefits to be paid directly to the doctor, and that the doctor may release any information to the insurance company required for processing any claims.
This authorization will remain in effect indefinitely.

Signature of patient_____

Date_____

If signed by another responsible person, specify relationship

Lisa McSweeney Counseling
PO Box 2127
113 S. Eunice
Port Angeles, WA 98362
(360) 808-1933

Intake Information

Personal Data
Please complete as fully as possible
Patient Name_____

Problems/Concerns that bring you to therapy:
_____
_____
_____

Goals for therapy (What are your expectations for a successful therapy experience?)
_____
_____
_____

Medications (prescription and over-the-counter) you are currently taking					
Name	**Dose**	**Purpose**	**Name**	**Dose**	**Purpose**
1			4		
2			5		
3			6		

Substances	**Quantity?**	**Behavior**	**Quantity?**
Alcohol		Overeating	
Tobacco		Gambling	
Marijuana		Compulsive sex/pornography	
Pills		Work	
Street drugs		TV/Internet	
Other:		Other:	

Serious illnesses or injuries:_____
_____
Chronic health problems:_____
_____
Family History of mental illness:_____
_____
_____
Family History of substance use:_____
_____
_____
Birth or early childhood accidents/complications_____
_____
_____