FOUNDATIONS, LLC

Forensic and Psychological Services

145 Santa Claus Lane South, Unit 2

North Pole, AK 99705

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CLIENT INTAKE FORM

Please provide the following information for our records. Information you provide is held in strict standards of confidentiality as required by state and federal law. PLEASE PRINT NEATLY.

Client Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if client is a minor):

_____
(Last) (First) (Middle Initial)

Birthdate: _____/_____/_____ Age: _____ Gender: _____ SSN: _____

Marital Status: _____

Race: _____ (optional)

Local Mailing Address: _____
PO Box or Street and Number, City, State, Zip

Home/primary phone _____ May we leave a message? _____

Cell/other phone _____ May we leave a message? _____

Email address _____

Emergency contact name: _____ Number: _____

* Preferred method of contact for appointment reminders (check one): _____ Email*# _____ Text*#

Referred by: _____

Employer: _____

Primary Insurance: _____

Insurance Address: _____
Street and Number, City, State, Zip

Group Number: _____ Insured's Identification/Benefits #: _____

Secondary Insurance: _____

Secondary Insurance Address: _____
Street and Number, City, State, Zip

Group Number: _____ Insured's Indentification/Benefits #: _____

Relationship of Insured to client: _____

I agree to the release of relevant information to my insurance carrier or other provider and to authorize payments to Foundations, LLC. This authorization is valid until I revoke it in writing.

_____

Signature Date

*** While we try to provide reminders of upcoming appointments as a courtesy to our clients, for various reasons we are not always able to do so. Failure to receive or see a reminder from us does not absolve you of your responsibility to make your scheduled appointments, provide a minimum of 24-hours notice of cancellation, or request rescheduling as outlined in your Client Services Contract.**

 # Email and text reminders are unencrypted, meaning the information they contain may be visible by an unknown/unauthorized third party. Selecting this option indicates your knowledge and approval of these methods of communication. *We will only include appointment information in these formats and discourage you from using them to send any information you want kept confidential.* Your initials indicate you have fully read and understand this information. _____ (initial)

MEDICAL HISTORY

Are you current receiving psychiatric services, professional counseling or psychotherapy? _____

If so, what is (are) the name(s) of the provider(s)? _____

_____

Have you had previous psychiatric services, professional counseling, or psychotherapy? _____

If so, what is (are) the name(s) of the provider(s)? _____

_____

Are you currently taking prescribed psychiatric medication? _____

If so, please list the medications: _____

_____

If no, have you been previously prescribed psychiatric medications? _____

If so, please list: _____

_____

HEALTH AND SOCIAL INFORMATION

How is your physical health at the present time? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Please list all medications and supplements that you are currently taking: _____

_____ _____ _____ _____

_____ _____ _____ _____

Are you currently having problems with your sleep? _____

If yes, which are applicable? (please circle)

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

Other:_____

How many times per week do you exercise and for how long each time? _____

_____

Are you having difficulty with appetite or eating habits? _____

If yes, which apply? (Please circle)

Eating less Eating more Binging Not eating

Have you experienced significant weight change in the last two months? _____

Do you regularly use alcohol? _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? (please circle)

Daily Weekly Monthly Rarely Never

Have you ever had substance abuse treatment? _____ If so, what date(s) and type(s) of treatment

_____

Have you had any suicidal thoughts recently? (please circle)

Frequently Sometimes Rarely Never

Have you had them in the past? (please circle)

Frequently Sometimes Rarely Never

Are you currently in a romantic relationship? _____

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

In the past year, please describe any significant life changes or stressors: _____

_____

Are you currently having any legal problems? _____ If so, please explain briefly _____

_____

Have you experienced:

Extreme depressed mood? _____

Wild mood swings? _____

Rapid speech? _____

Extreme anxiety? _____

Panic attacks? _____

Phobias? _____

Hallucinations? _____

Unexplained memory lapses? _____

Alcohol/substance abuse? _____

Frequent body complaints _____

Body image problems _____

Repetitive thoughts _____

Repetitive behaviors _____

Homicidal thoughts _____

Suicide attempt _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with the following? (Please circle any that apply and list family members.)

Difficulty	**Family Member**
Depression	_____
Bipolar Depression	_____
Anxiety Disorders	_____
Panic Attacks	_____
Schizophrenia	_____
Alcohol/Substance Abuse	_____
Eating Disorders	_____
Learning Disabilities	_____
Trauma History	_____
Suicide Attempts	_____

_____

Signature (Guardian's signature if you are a minor) Date