Welcome! Thank you for choosing SPSI for your healthcare needs. To help us help you, please fill out this form to the best of your ability. If you have any questions, our staff will be happy to help.

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Soc Sec #: _____
Last First Middle

Gender: M F Race: _____ Marital Status: ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced

Phone Number: ( ) _____ Alternate Phone: ( ) _____ This is my (_____) phone

Address: _____
Street Apt, Suite, etc. City, State ZIP

Employed By: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Who may we thank for referring you? How did you learn of our practice? _____

Where do you prefer to receive calls? _____ Any special instructions regarding telephone calls? _____

When is the best time to reach you? Days: _____ Times: _____

EMERGENCY CONTACT INFORMATION

Contact person: _____ Relation: _____ Home #: _____ Work #: _____

Name of Primary Physician: _____ Phone: _____ Hospital: _____

Date of Last Physical Exam: _____ Medical Conditions: _____

Allergies: _____

RESPONSIBLE PARTY

Responsible Party: _____ Relation: _____ Date of Birth: _____
Last First Middle

Driver's License #: _____ Soc Sec #: _____ Phone: _____

Employed by: _____ Occupation: _____ Work Phone: _____

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance	Other Insurance
Effective Date			
Policy Holder			
Relation to Client			
Policy Holder Date of Birth			
Soc Sec #			
Employer			
Date Employed			
Occupation			
Ins. Company			
Group #			
Contract #			
Deductible Amount			

FINANCIAL ARRANGEMENTS

We ask payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer:

○ Cash ○ Check ○ Credit Card ○ Payment Plan

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing, I realize a late charge of 1.5% on the balance then unpaid will be owed and will be assessed monthly. I realize that failure to keep the account current may result in you being unable to provide additional services, except for emergencies or where there is prepayment for additional services.

ASSIGNMENT AND RELEASE

AUTHORIZATION, ASSIGNMENT, AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners or to persons designated as emergency contacts.

I assign directly to Saginaw Psychological Services, Inc. (SPSI) all medical benefits, if any, otherwise payable to me for services rendered. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, whether or not paid by insurance. I hereby authorize Saginaw Psychological Services, Inc. (SPSI) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Saginaw Psychological Services, Inc. (SPSI) for any services furnished to me by SPSI. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Saginaw Psychological Services, Inc.

ADULT INTAKE

Client Name: _____ Client #: _____ Date: _____

Age: _____ Gender: ○ Male ○ Female Marital: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Race: ○ Caucasian ○ African American ○ Hispanic/Latino ○ Native American ○ Asian ○ Other _____

Description of Problems and Onset

State in your own words the nature of your problem(s), i.e. the reason you are seeking professional assistance today.

_____

_____

_____

_____

Please check the box below that best describes the severity of your problem(s).

○ Mildly Upsetting ○ Moderately Upsetting ○ Upsetting ○ Severe ○ Totally Incapacitating

What do you hope/want counseling to accomplish? What will be different?

_____

_____

Do you or have you ever had thoughts or acted on thoughts of hurting yourself or others?

___ Yes ___ No *If yes, explain briefly.*

_____

_____

Do you have any other risk-taking behaviors or concerns? ___ Yes ___ No *If yes, explain briefly.*

_____

_____

Please check the box or boxes below which pertain to the symptoms you are currently experiencing.

○ Sad / depressed mood ○ Hyperactivity ○ ___ Perpetrator ___ Victim of ___ Emotional ___ Physical ___ Sexual abuse.

○ Decreased Energy ○ Difficulty Concentrating ○ Substance Abuse ○ Grief

○ Hopelessness ○ Worried, Stressed, Anxious ○ Panic Attacks ○ Irritability

○ Hallucinations ○ Anger ○ Other:_____

○ Changes in your ___ eating patterns ___ sleeping patterns. *If this box is checked, please explain briefly.*

_____

○ Fears of: _____

○ Preoccupation with: _____

Who else would you like involved in your treatment?

_____

_____

PSYCHIATRIC / PSYCHOLOGICAL

Have you ever been in therapy before? ___ Yes ___ No *If yes, indicate the dates, place(s), type(s), purpose(s), and resultant diagnosis(es), of therapy you were involved in.*

From	*To*	*Location*	*Type/purpose of therapy/diagnosis*

History / Current Status

FAMILY OF ORIGIN
In the table below, please indicate the names and ages of your family of origin (including parents, step parents, brothers, and sisters), whether they are still living, their history of substance abuse/mental health problems, the quality of your relationship with them (i.e. do you have a good relationship with them), and any additional comments you feel are necessary to accurately portray your relationship with that person. If you were raised by a relative other than your parents, please include them in the extra spaces provided.

Relation	**Name**	**Age**	**Living?** (Y/N)	**History of Substance Abuse or Mental Heath Problems?** (Y/N)	**Quality of Relationship**	**Comments**
Mother						
Father						
__ Brother __ Sister						
__ Brother __ Sister						
__ Brother __ Sister						
__ Brother __ Sister						

Who were you raised by? _____ *If other than parents, please explain why briefly.*

Were you ever physically, emotionally, or sexually abused? ___ Yes ___ No *If yes, please explain extent of abuse and person(s) involved*

Please indicate any other information you feel is necessary to understand your relationship with your family of origin.

CURRENT FAMILY
Please indicate your current marital status:

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Living with Significant Other

For how long? ____ *If you have had previous marriages, significant relationships, approximately how many:* ____

Do you have any children? ___ Yes ___ No *If yes, please indicate name(s), age(s), type of child, and living situation.*

Name	*Age*	*Biological, Adopted, or Stepchild*	*Live w/You?* (Y/N)

SOCIAL / INTERPERSONAL RELATIONSHIPS

Do you have any close friends? ___ Yes ___ No *If yes, approximately how many close friends do you have?* _____

How frequently do you see your friends? ___ Daily ___ Weekly ___ Monthly ___ Other: _____
How would you describe your relationship with your friends, are they supportive of you?

Do you have any other social supports? ___ Yes ___ No *If yes, please explain briefly.*

SPIRITUAL
Are you an active member of a religion? ___ Yes ___ No *If yes, what is your preferred religion?* _____
Is there anything you would like us to take into consideration regarding your religion while developing a treatment plan?

CULTURAL
Do you identify yourself with a particular cultural or ethnic group? ___ Yes ___ No *If so, explain briefly.*

LEISURE ACTIVITIES / INTERESTS / HOBBIES
What do you like to do for fun?

FINANCIAL
Are you currently experiencing any financial difficulties? ___ Yes ___ No *If yes, explain briefly.*

HOME / LIVING ENVIRONMENT

Please indicate your current living environment: ___ House ___ Mobile Home ___ Apartment ___ Other: _____

Besides yourself, how many people are currently living in your home? ___ *Any other living environment information?*

EDUCATION
What is the highest grade of school you completed? _____ *Were you ever in special education?* ___ Yes ___ No

Are you currently enrolled in any classes? ___ Yes ___ No *If so, where?* _____
Indicate below which schools you attended in the past, including elementary, middle, and high schools and any college.

EMPLOYMENT

Are you currently employed? __ Yes __ No *Employer:* _____ *Occupation:* _____

___ Full Time ___ Part Time *How many hours per week?* ___ *How long have you had this job?* _____

Have you ever had any other jobs in the past? ___ Yes ___ No *If yes, how many?* _____

Indicate your job performance, and any difficulties you have had or are experiencing with your current job.

_____

_____

SUBSTANCE USE

Have you ever used drugs or alcohol? ___ Yes ___ No *If yes, please fill out the table below. Indicate the substance name, the amount used, the frequency (e.g. daily, weekly, etc.) used, the first date of use, most recent use, and any comments you may have pertaining to the use of that substance.*

Substance	*Amount*	*Frequency*	*First Use*	*Last Use*	*Comments*
Alcohol					

Do you believe you have an alcohol or drug problem? ___ Yes ___ No *Your drug of choice?* _____

Do you smoke cigarettes? ___ Yes ___ No *How many per day?* _____

Over-the-counter medication? ___ Yes ___ No *Which medication(s)?* _____
Is there anything else you would like us to know concerning your past or current alcohol / drug use?

_____

_____

MEDICAL

How would you rate your current health? ___ Good ___ Fair ___ Poor *Currently in treatment?* ___ Yes ___ No
If you are currently in treatment, or your health is other than good, explain briefly.

_____

Current primary care physician: _____ *Last date seen:* _____

Indicate the dates of any serious illnesses, injuries, surgeries, or hospitalizations: _____

_____

Indicate any allergies you may have: _____

_____

Does your family have any significant medical history? _____

_____

Sexual orientation? _____ *Do you have any sexual / medical concerns?* ___ Yes ___ No *If yes, briefly explain:*

_____

HIV Assessment: Have you had: multiple sexual partners? ___ Yes ___ No *injected drug use?* ___ Yes ___ No

unprotected sex? ___ Yes ___ No *blood transfusion(s)?* ___ Yes ___ No

exposure to blood and/or blood products? ___ Yes ___ No

LEGAL

Are you currently having any legal problems, or have you had any in the past? ___ Yes ___ No *If yes, explain briefly.*

ADJUSTMENT

Summarize briefly what sorts of things have changed in your life due to the current problem(s) for which you are now seeking care.

MILITARY / OTHER

Please indicate any military service in the space below if applicable. Also, if there is any other information you would like to provide us with that you feel may be relevant to your treatment and/or treatment planning here at SPSI, please feel free to make a note of it here.

Saginaw Psychological Services, Inc.

Medication Summary

Client Name: ______________________________ Client #: ______________________ Date: ________________

Are you allergic to any medications? ___ Yes ___ No *If yes, indicate the names of the medications in the space provided below.*

____

____

Do you take your medications only as prescribed? ___ Yes ___ No

In the spaces provided below, please note ***each medication that you are currently on, or have been on in the past*** *along with the requested information. Make sure to also* ***include any over-the-counter/non-prescription medications you are currently taking****. If you do not know a certain item, leave it blank. If you need more space, please contact the front desk for an extra page or two. An example is provided in the first block for your convenience.* ***Please include in the notes section the effectiveness of the medication, any side effects or reactions you experienced while taking it, and if you discontinued it, why you did so.***

EXAMPLE

Medication:	Ritalin					**Notes:** Works well to control mood, causes
Rx By:	Dr. Smith			**Dosage:**	50mg	difficulty sleeping at times, weight loss (7 lbs)
Freq:	1 time daily	**Start:**	5/7/2003	**End:**		
For: ADHD						

Note: The 'Start' field pertains to when you first started taking the medication, and the 'end' field pertains to when you stopped taking it. If it is a current medication, leave the 'end' field blank.

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						

Medication:						**Notes:**
Rx By:				**Dosage:**		
Freq:		**Start:**		**End:**		
For:						