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Adult Intake Form - Counseling

Name _____ Age _____ Birthdate _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How long have you both been together? _____ Religion _____

Name of person responsible for fees: _____

Name closest friend/relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

Do you smoke? How much? _____ Do you drink? _____ How much? _____

Do you take drugs? _____ If yes, what kind? _____ How often? _____

Medical Information and History:

Name of Primary Care Physician: _____

Address _____ Phone _____

Last Medical Examination _____ Reason _____

Are you now under a Doctor's care? If yes, Doctor's name _____

Reason for Doctor's care _____

Are you taking any Medication? _____ If yes, what kind and dosage? _____

Reason for medication _____

Have you ever been hospitalized for a physical illness? Describe: _____

Have you been diagnosed with a chronic illness? If yes, please explain: _____

Check Any of the Following That May Apply to You:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Shy With People |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> Can't Make Friends |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Feel Panicky | <input type="checkbox"/> Afraid of People |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Fears and Phobias | <input type="checkbox"/> Home Conditions Bad |
| <input type="checkbox"/> Over-Eating | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Unable to Have a Good Time |
| <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Depressed | <input type="checkbox"/> Always Worried |
| <input type="checkbox"/> Bowel Disturbances | <input type="checkbox"/> Suicidal Ideas | <input type="checkbox"/> Don't Enjoy Weekends/Vacations |
| <input type="checkbox"/> Always Tired | <input type="checkbox"/> Take Tranquilizers | <input type="checkbox"/> Difficulty Making Decisions |
| <input type="checkbox"/> Cries Easily and Often | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Over-Ambitious |
| <input type="checkbox"/> Unable To Relax | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Nonprescription Drug Use |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Allergies | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Recurrent Dreams | <input type="checkbox"/> Asthma | <input type="checkbox"/> Job Problems |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Can't Keep a Job |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> Other |

Social/Mental/Emotional Information and History:

Have you ever been hospitalized for a mental illness, personality disorder, anxiety disorder, etc?

Describe: _____

Have you had any previous therapy/counseling? _____ If yes, name and phone numbers of

Therapists: _____

Beginning and ending dates of therapy and number of sessions: _____

Type of Therapy/Counseling: _____

What did you achieve with prior therapy? _____

How were you referred to Pinnacle Mental Wellness Group?: _____

What do you hope to achieve with therapy? _____

What, if any, questions do you have about therapy? _____

Payment and Insurance Information:

PLEASE NOTE: ALL FEES NEED TO BE PAID AT THE TIME OF SERVICE. There are three options, outlined below, for payments and billing. Please choose the option that best suits your need below by **initialing** your choice.

Name of financially responsible person: _____

_____ **I would like PMWG to Superbill my insurance on my behalf.**
Initial choice

If you want us to Superbill your insurance for you, please provide the following information:

- Name of Insured: _____
- Insured's Date of Birth: _____
- Relationship to client: _____
- Insured's Address: _____
- Insured's phone #: _____
- Insured's Employer: _____

Please also provide a copy of your insurance card, front and back.

PLEASE NOTE: As a courtesy to our clients we will bill your insurance on your behalf. However, you are still responsible to pay for the all session/treatment fees upfront and on the day of service. Your insurance, if it covers our services, will reimburse you directly.

_____ **Credit Card payment option**
Initial choice

Yes, I want my credit card billed for my child's session. You can elect to have a credit card on file that will be automatically billed after each of your child's session are completed. If you would like to use this payment option please fill out the **Credit Card Form**.

_____ **I have CCHP Insurance for my child and a valid AUTHORIZATION for services with Pinnacle Mental Wellness Group.**
Initial choice

I am a member of CCHP Insurance and I have already called and have a valid authorization in place for my child's treatment. I understand that whatever fees are not covered by CCHP (late fees, insufficient funds for co-pays, additional testing fees, lapse in coverage, etc) are my financial responsibility.

Upon my signature below, I hereby attest that all of the information furnished is true and correct.

Signature

Date

Print Name