PINNACLE
Mental Wellness Group
A Family Counseling Community, Inc.

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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:

- [ ] Headache
- [ ] Dizziness
- [ ] Fainting Spells
- [ ] No Appetite
- [ ] Over-Eating
- [ ] Stomach Trouble
- [ ] Bowel Disturbances
- [ ] Always Tired
- [ ] Cries Easily and Often
- [ ] Unable To Relax
- [ ] Insomnia
- [ ] Recurrent Dreams
- [ ] Nightmares
- [ ] Hallucinations
- [ ] Inferiority Feelings
- [ ] Feel Tense
- [ ] Feel Panicky
- [ ] Fears and Phobias
- [ ] Obsessions
- [ ] Depressed
- [ ] Suicidal Ideas
- [ ] Take Tranquilizers
- [ ] Alcoholism
- [ ] Financial Problems
- [ ] Allergies
- [ ] Asthma
- [ ] Lack of Motivation
- [ ] Sexual Issues
- [ ] Shy With People
- [ ] Can't Make Friends
- [ ] Afraid of People
- [ ] Home Conditions Bad
- [ ] Unable to Have a Good Time
- [ ] Always Worried
- [ ] Don't Enjoy Weekends/Vacations
- [ ] Difficulty Making Decisions
- [ ] Over-Ambitious
- [ ] Nonprescription Drug Use
- [ ] Gambling
- [ ] Job Problems
- [ ] Can't Keep a Job
- [ ] 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 four options, outlined below, for payments and billing. Please choose the option that best suits your need by ***initialing*** your choice.

Name of financially responsible person: ____

____________ **Initial choice**

I would like PMWG to Superbill my insurance on my behalf.

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.

____________ **Initial choice**

Credit Card payment option

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

____________ **Initial choice**

I have CCHP Insurance or another In-Network Insurance.

I am a member of CCHP Insurance or another in-network insurance and I have already called and have a valid authorization in place for my treatment (if one is required). 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. I understand that my co-payment, if I have one, is due at each visit.

____________ **Initial choice**

EAP Option

I have benefits through my work Employee Assistance Program. I have been approved for

______ sessions.

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

____ ______________________________

Signature Date

____

Print Name