Paulette Trueblood, M.A.
Licensed Marriage & Family Therapist
Psychotherapy/Counseling
Individual, Couple, Family & Group
101 Harbor Rd • Southport CT 06890
Telephone: 203 254-826

ADULT INTAKE FORM

Date:

Who may we thank for referring you?

CLIENT INFORMATION

Name:	Home Phone #:
	Cell Phone #:
Address:	E-mail address:
Employer's Name	Occupation
Work Address:	Work Phone #:
Birth Date:	Age:
Social Security #:	
Marital Status:	
Spouse or Significant Other Name:	Age: Birth Date:
Children's Names:	Age: Birth Date:

What symptoms motivated you to seek counseling?

What is your desired outcome for these sessions?

Previous counseling/therapy (include any prior history of counseling for mental health, alcohol or other drug problems:

Psychiatric	Substance Abuse	Treatment Outcomes
☐ None	☐ None	
☐ Outpatient	☐ Outpatient	
☐ Inpatient	☐ Inpatient	
☐ Within last 12 months	☐ Within last 12 months	
☐ One prior admission	☐ One prior admission	
☐ 2 or more prior admission	☐ 2 or more prior admissions	

Medical History

Major illnesses (physical or mental), injuries or chronic problems, which have required attention currently and/or in the past?

Is there any medical illness, alcoholism, substance abuse or psychological disorder that seems to run in the family? Please explain.

List your allergies:

Are you currently taking any medication? ☐ Yes ☐ No

Name of medications & for what condition?

Do you give your permission to contact the prescribing physician ☐ Yes ☐ No

What is the physician's or medication management person's name and contact information?

Has any significant personal or family event occurred recently? Circle event(s) on the list below. Indicate when & briefly describe. Use reverse side of this sheet, if necessary.

A. Death; B. Pregnancy/Birth; C. Separation/Divorce (or threat of): D. Child entered school for first time; E. Child reached adolescence; F. Career or business readjustment; G. Accident or serious injury/illness (you or family); H. Legal problems (you or family); I. Mid-life change.

In case of an emergency, who do we have permission to notify:

Name & Relationship to you:

Address

Telephone #:

Signature: Date:

INSURANCE INFORMATION

Subscriber's Name:	Subscriber's Birth Date:
Subscriber's Address	
Subscriber's Social Security No.	
Insurance Co:	Subscriber's ID #:
Insurance phone #:	Client's ID#:
Subscriber's Employer:	
Secondary Insurance Co:	ID #:

Primary Care Physician's Name & Address (required by BC/BS, Anthem):

Do you want me to communicate with your primary care physician regarding your sessions with me in order to coordinate care? ☐ Yes ☐ No

SIGNATURE REQUIRED IN ORDER TO COLLECT INSURANCE PAYMENT

1. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE FOR INSURANCE AUTHORIZATION: the statements are true and correct to the best of my belief. I authorize any insurance company, organization, hospital, physician or other healthcare vendor providing service or benefits to me to release any mental health, substance abuse, assessment or medical treatment information necessary to affect treatment or claim payment. I understand that confidential mental health and medical information will not be released to my employer, family members or others not identified without my consent.

2. I authorize payment of medical benefits to the Paulette Trueblood MA, LMFT for individual psychotherapy (90804 or 90806, 90806), Family Psychotherapy (90847), evaluation (90801) and Psychotherapy without the Patient (90846).

Signature **Date**

I send information to clients about classes that I teach as well as articles of interest. If you **do not** want to be on the mailing list please **initial here ……**

Client Name: _____Date:_____

Symptoms (Please check all that apply. Those not checked will be assumed absent.)

Sad or Blue ☐Mild ☐Moderate…☐Severe	Hyperactivity ☐Mild ☐Moderate…☐Severe	Are you in early remission from substance abuse?
Depressed mood ☐Mild ☐Moderate…☐Severe	Impulsivity ☐Mild ☐Moderate…☐Severe	Are you in full-sustained remission from substance abuse?
Decreased energy or fatigue ☐Mild ☐Moderate…☐Severe	Distractible ☐Mild ☐Moderate…☐Severe	Emotional/physical/sexual trauma victim
Feel hopeless about future ☐Mild ☐Moderate…☐Severe	Moods change quickly ☐Mild ☐Moderate…☐Severe	Emotional/physical/sexual trauma perpetrator
Loss of interest in things ☐Mild ☐Moderate…☐Severe	Nervousness or shakiness ☐Mild ☐Moderate…☐Severe	Eating Problems: ☐Binging
Feel unmotivated ☐Mild ☐Moderate…☐Severe	Anxious ☐Mild ☐Moderate…☐Severe	☐Purging ☐Restricting
Feel irritable ☐Mild ☐Moderate…☐Severe	Your heart pounding or racing ☐Mild ☐Moderate…☐Severe	Do you have homicidal thoughts? Please explain.
Feel overwhelmed ☐Mild ☐Moderate…☐Severe	Hallucinations ☐Mild ☐Moderate…☐Severe	
Decrease in appetite ☐Mild ☐Moderate…☐Severe Increase in appetite ☐Mild ☐Moderate…☐Severe	Persistent ideas, thoughts, images that cause marked anxiety or distress ☐Mild ☐Moderate…☐Severe	Do you have suicidal thoughts? ☐Mild ☐Moderate…☐Severe
Problems concentrating ☐Mild ☐Moderate…☐Severe	At times, do you feel like an outside observer of your actions? (depersonalization) ☐Mild ☐Moderate…☐Severe	What means would you use to commit suicide?
Complaints about bodily pains ☐Mild ☐Moderate…☐Severe	Do you prevent anxiety by using repetitive thoughts? (counting, praying) ☐Mild ☐Moderate…☐Severe	Do you have a plan to commit suicide?
Sleep Problems: ☐Falling asleep? ☐Awaking during sleep? ☐Waking too early? ☐ Sleeping too much	Do you prevent anxiety by using repetitive behaviors (ordering, checking, washing) ☐Mild ☐Moderate…☐Severe	In the past month have you ever felt you ought to cut down on your drinking or drug use? In the past month have you felt bad or guilty about your drinking or drug us?

Number of cigarettes smoked per month? Per week? Per day?	Number of alcoholic beverages consumed per month? Per week? Per day?
Do you use illegal drugs?	If yes, what illegal drugs do you use? How often?

TREATMENT PLAN

AXIS I:	**AXIS II:**	**AXIS III:**
AXIS IV:		**AXIS V:**
PROBLEMS:		
GOALS:		
OBJECTIVES/APPROACHES:		

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INFORMED CONSENT AND AUTHORIZATION PSYCHOLOGICAL TREATMENT

Sessions are 45-50 minutes. Fees for clients using health insurance vary, and are determined by the insurance company contract agreement with P. Trueblood. Client responsibility with insurance is usually a co-pay and/or deductible. If the client's insurance company does not pay for the sessions, the standard fees are the client's responsibility. Standard fees are $175 for the first evaluation session and $150 for following sessions.

Scheduled sessions that are cancelled less than 24-hours in advance are subject to a $70 missed session fee.

I understand that P. Trueblood, MA, LMFT will provide me with mental health services. These services may consist of interviews, treatment sessions, the administration of various self-evaluation scales, the review of various documents and records from my background, and interviews with other individuals who are familiar with me. Everything that is said during the course of my treatment is protected under my rights to confidentiality and will not be conducted or released without my expressed and written authorization.

I realize that certain types of information revealed during the course of these services may result in other agencies or people being notified, even though they are not directly involved in my treatment. Examples of such information include reports of child abuse (past and present), elder and/or dependent adult abuse, threats to kill or violently harm others, and threats to harm myself.

A limited exception to confidentiality may exist in the case of third-party payers (insurance companies, employee assistance plans, victims assistance programs, and health maintenance organizations), and will be limited to reporting my diagnosis and treatment needs in order to satisfy billing requirements. I also understand that in the case of delinquent accounts, a collection agency may be employed to seek payment; however, information released to them will consist solely of session dates and account balances.

I understand that at times Paulette Trueblood may use various professional copying, test scoring and other professional services and that she may consult with other professionals as part of ongoing professional education, research and workshop presentations. At all times P. Trueblood will protect my privacy by not revealing my name or other unique identifying characteristics

I understand that there may be alternative treatment methods for my condition, and that I can discuss these alternatives with Paulette Trueblood at any time. I also understand that I may choose to terminate treatment at any time with the understanding that a final session focused on termination issues is advisable. I am aware that there are risks associated with psychotherapy – and these may include lack of improvement, disruptions in my life that can occur as a result of therapeutic changes, and emotional pain associated with the exploration of personal issues.

I have read (or have had read to me) the information in this authorization and consent and I have asked questions about anything I have not understood. By signing this form, I freely acknowledge my willingness to undergo the treatment to be performed by Paulette Trueblood and release her of any liability that might directly or indirectly result from the release or exchange of any information covered by this form. We will provide you with a copy of this form on request.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Signature 1 _____ Signature 2 _____ Dated _____

Parent or guardian signature _____ Dated _____

Therapist _____ Dated _____