Beverly J. Paschal, Ph.D.
Licensed Marriage and Family Therapist

ADULT INTAKE FORM

Please provide the following information and answer the questions below.

Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session OR email it to: bjpaschal@aol.com

Name:_____
Last First Middle Initial Prefers to be Called

Address:_____
Number Street City State Zip Code

Home Phone: ( ) _____ May we leave a message? ☐Yes ☐No
Cell Phone: ( ) _____ May we leave a message? ☐Yes ☐No
Work Phone: ( ) _____ May we leave a message? ☐Yes ☐No

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐Male ☐Female

Marital Status: ☐Never ☐Married (years)_____ ☐Domestic Partnership (years)_____

☐Separated ☐Divorced (year)_____ ☐Widowed (year)_____

How many marriages: _____ How many divorces: _____

Employer: _____ Position: _____

Please list any children & age:_____
_____
_____

Have you ever been arrested: _____ If so, what year and what for: _____
_____
_____

E-mail: _____ May we email you? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship?

11. Have you had any life changes or stressful events recently:

_____

_____

_____

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FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Yes or No	List Family Member
Alcohol/Substance Abuse	☐ yes/no ☐	_____
Anxiety	☐ yes/no ☐	_____
Depression	☐ yes/no ☐	_____
Domestic Violence	☐ yes/no ☐	_____
Eating Disorders	☐ yes/no ☐	_____
Obesity	☐ yes/no ☐	_____
Obsessive Compulsive Behavior	☐ yes/no ☐	_____
Schizophrenia	☐ yes/no ☐	_____
Suicide Attempts	☐ yes/no ☐	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Beverly J. Paschal, Ph.D.
Licensed Marriage and Family Therapist
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3670 Grant Drive, Suite 103-A
Reno, Nevada 89509
Phone ~ (775) 827-0404 ~ FAX
(775) 788-4135 ~ Pager
bjpaschal@aol.com

HIPAA NOTICE SIGNATURE FORM

You have been provided with a document titled:

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION.

Your signature below indicates that you have read this document and/or been given a copy for your own records.

_____

_____
Patient Name Signature Date

_____
Patient or Parent or Guardian Signature Signature Date

_____
Beverly J. Paschal, Ph.D. Signature Date
~~~~~~~~~~~~~~~~~

Beverly J. Paschal, Ph.D.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

Beverly J. Paschal, Ph.D.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of $175 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency**.** A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Guardian if Appropriate)

_____

Today's Date

Beverly J. Paschal, Ph.D.
Licensed Marriage and Family Therapist
3670 Grant Drive, Suite 103-A
Reno, NV 89509

Phone (775) 827-0404
FAX (775) 827-0404
bjpaschal@aol.com

PATIENT NAME: _____ DATE: _____

FEE AGREEMENT AND FINANCIAL POLICY

Print Name of Person Financially Responsibility: _____

Signature of Person Taking Financial Responsibility: _____

Relationship to Patient if Other Than Self: _____

DATED: _____

A receipt will be e-mailed to you at the email you provide: _____

Type of Card: ____Visa _____Mastercard ____American Express ____Discover_____

Name on credit card: _____Digits on Back:_____

Card # (16) Digits:_____

Expiration Date: _____ Zip Code You Receive Statement At: _____

Beverly J. Paschal, Ph.D. will send you a receipt of every time your card is charged.

INSURANCE PAYMENTS

Please also fill out the Insurance Form if you want me to bill your insurance for you. Your Insurance Payments will come to you unless the parents are divorced and each are paying 50%. In which case, the insurance payment will come to me and I will issue the insurance reimbursement money to each parent.

I authorize Beverly J. Paschal, Ph.D., to charge this credit card as needed according to the terms specified in this agreement and policy.

Signature: _____ Date: _____