RCC Riley Counseling and Consulting, PLC

OUTPATIENT INTAKE FORM

The information you provide is confidential and used for clinical and billing purposes only.

CLIENT INFORMATION

Date: ________________

Client's Name: ___________________ ___________________ _________________
First Middle Last

SSN: _______________________________ Date of Birth: ______________________

Age: ___________ Gender: ____Male ____Female

Address: ____

City: ______________________________ State: ____________ Zip Code: __________

Home Phone: _______________________ Work Phone: ________________________

Cell Phone: _________________________ Pager: ______________________________

Email: ____

Preferred method of contact? ___Home ___Work ___Cell Phone ___ Email

___Other: _______________________________________

Please indicate any numbers we do NOT have permission to call: ___________________

Emergency Contact Name: _________________ Phone: __________________________

Relationship to Client: _________________

Relationship Status: __Single __Married __Separated __Divorced ___Widowed

__Domestic Partner

Race/Cultural Background: ____

Spiritual/Religious Affiliation: ____

Occupation: ____

Place of Employment: ____

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Reason for your visit today?
____

Current/Previous Mental Health Diagnosis? ______ No ______ Yes

If Yes, What is/was the diagnosis (es) and when were you diagnosed?
____
____
____
____

Previous Mental Health Treatment? ______ No ______ Yes

If Yes, When/Where/Reason:
____
____
____
____

History of Substance Abuse/Dependence? ________No ________Yes

If Yes, Substance(s) of Choice? Current? Past? (When) Any Treatment? (When):
____
____
____
____

Legal History? ________No ________Yes

If Yes, explain:
____
____
____
____

Medical Problems/Illnesses (history/current)?
____
____
____

Allergies? ____

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Current/Past Psychotropic Medications? ________No ________Yes

If Yes, Please List Below:

Past/When:	Current:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Current/Past Suicidal Thoughts or Thoughts of Self-Harm? ________No ________Yes

If Yes, explain:

____
____
____
____

Past Suicide Attempts or Self-Harm Behaviors? ________No ________Yes

If Yes, explain:

____
____
____
____

History of physical, sexual or emotional trauma? ________No ________Yes

If Yes, explain:

____
____
____
____

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PAYMENT INFORMATION

Self-Pay (out-of-pocket): ______Yes______No **(If GROUP-indicate 'yes'-no insurance info needed)**

Insurance Provider: ____

Address: ____
____
____

Phone(s): ____

Policy/Group Number: ____

Customer/Member Number: ____

***How did you hear about us? ___Website ___Parent ___Friend ___Family Doctor**

___Court ___Other: ______________________________

Person completing the form if other than client: ____________________________

(Reason? ____)

Signature: ____

Client Signature: ____

Parent/Guardian/Spouse (if applicable): ____________________________________

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read the Informed Consent and the Notice of Privacy Practices and agree to their terms.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

Date ________________________________
Description of Personal Representative's Authority: ___________________________