Jessica L. Long, Psy.D.

Licensed Clinical Psychologist

Client Intake Information - ADULT

Personal Information

Client's Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

I give my permission to be contacted at the following telephone numbers/email regarding appointments:

Home _____ Work _____

Cell _____ Email _____

Messages can be left at: _____

Insurance Information

Primary Insurance Co _____ Ins. Phone # _____

Member ID _____ Group # _____

Insured's Name: _____ Relationship to Client: _____

Insured's Date of Birth: _____ Insured's Soc. Sec. #: _____

Insured's Address: _____ Phone: _____

**Please note, we do not bill secondary insurance but can provide you with documentation to submit to your secondary insurance company.*

Have you contacted your insurance to verify your mental health benefits? ___ yes ___ no

Is Jessica L. Long, Psy.D. an in-network provider of your insurance? ___ yes ___ no

If no, are out of network benefits available? ___ yes ___ no

If yes, do you need *prior authorization*? ___ yes ___ no # of sessions allowed? _____

Do you have a deductible? ___ yes ___ no

If yes, what amount? _____ Amount reached? _____

Do you have a co-pay or co-insurance? ___ yes ___ no If yes, what amount? _____

Person Completing Form:_____ Relationship to Client: _____

Emergency Contacts with whom I permit contact in case of emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Reason for Treatment

Reason you are seeking services at this time?

Who referred you to our office?

What difficulties are you experiencing? *(Please describe- emotional, medical, occupational, social, marriage, parenting, etc).*

How have these difficulties changed over time? *(Began when, worsened, stayed the same, improved)*

What are your greatest concerns about your functioning?

What goals do you have for assessment and/or treatment?

Family Information

Who Lives In Your Home?

Name	Age	Relationship

Marital Status?

___ Single ___ Married ___ Partnered ___ Widow(ed) ___ Divorced ___ Separated

Medical History

Name of Primary Care Physician: _____ Phone: _____

Current Medical Problems: _____

Current Medications/Dosage: _____

Other involved providers (type): _____

Mental Health History

History of mental health issues (please describe)? _____

_____

Prior mental health treatment (please describe- when, with whom)? _____

_____

Prior hospitalizations for mental health treatment (please indicate when)? _____

_____

Family history of mental illness (diagnosed or undiagnosed)? _____

_____

Other Information

During the past 12 months, have you/your family experienced any of the following? *Circle all that apply.*

Death of a family member Serious illness Occupational Stress Financial Stress

Marital problems Family Conflict Other:

Employment Status:

Full/Part Time Homemaker Unemployed

Place of Employment: _____ Position: _____

Education:

Highest Level of Education Completed? _____ Type of Degree? _____

Current Student? Yes/no If yes, what are you studying? _____

Religious/Spiritual Affiliations? _____

How might this affect your treatment experience? _____

_____

Cultural Factors for consideration or that may impact treatment (If any, please describe)?_____

_____

Are there any other factors you feel will impact your treatment (If any, please describe)? _____

_____

Acknowledgement of Office Policies, Privacy Practices, Consent for Treatment & Payment Responsibility

I have received a copy and had the opportunity to review the Office Policies, Electronic Communications Policy, Client Rights, and Privacy Practices provided to me by Jessica Long, Psy.D. I have had the opportunity to have answered any questions I might have about these policies.

I give my permission for Jessica L. Long, Psy.D. to provide treatment to me.

I have read and understand the Financial Agreement information contained in this form. I certify that the information I provided is correct to the best of my knowledge and I acknowledge that I am responsible for payment of the services rendered by Jessica Long, Psy.D. If I choose to use insurance coverage, my co-payment and/or percentage of the bill are due at the time of service. I authorize Jessica Long, Psy.D. and her administrative and billing staff and/or any collection agencies used by Jessica Long, Psy.D., to contact me by phone and/or mail for billing activities or payment arrangements.

_____ _____

Client Signature Date