Kim T. Hoffman, Ph.D.
Dormont, PA 15216
Phone: 412.719.0957
Fax: 1.877.742.6060
Website: www.DormontPsychServices.com
Email: DormontPsychServices@yahoo.com

ADULT INTAKE FORM

PERSONAL INFORMATION

Client Name	
DOB	
ADDRESS	
Phone (home)	OK to call Yes ____ No____ Preferred?____
Phone (cell)	OK to call Yes ____ No____ Preferred?____
Phone (work)	OK to call Yes ____ No____ Preferred?____

Please list all those you are living with:

Name	Age	M/F	Birth Date	Relationship	Education	Occupation

Feel free to list other important relationships (step children living out of the home, others you care about or for):

Name	Age	M/F	Birth Date	Relationship	Education	Occupation

MEDICAL INFORMATION

Physician: ____

Describe any health problems you (client) have: ____

Current medications: ____

Any serious/chronic illnesses: ____

Prior surgeries: ____

Previous counseling or therapy: No_____ Yes_____ When?_________________________________

Counselor Name or Agency Name: ____

What was the concern? ____

Have you ever been hospitalized for psychiatric treatment? No_____ Yes_____ When?_________________________________

Where were you hospitalized? _______________________________For how long? ____________________________________

What brings you to treatment now? ____

How long have your current problems existed? ____

Describe your present concerns: (Circle one) Mild Moderate Moderately Severe Severe A Crisis

How did you learn about me? ____

Emergency contact person: ____
(Name) (Relationship) (Phone)

PLEASE MARK ALL THAT APPLY;

_____crying spells
_____unable to have fun
_____feelings easily hurt
_____lacking in confidence
_____constipation
_____feeling grouchy
_____always tired
_____poor appetite
_____cold feet and hands
_____trouble sleeping
_____feeling lonely
_____weight loss/gain
_____not enjoying things
_____suicidal thoughts
_____feeling inferior
_____loss of sexual interest
_____no one understands me
_____worried about health
_____can't concentrate
_____can't "get going"
_____feeling angry
_____don't like being alone

_____lack energy
_____always worried
_____frequent sweating
_____dizziness
_____shaky hands
_____stomach trouble
_____nightmares
_____excessive drug use
_____problems with children
_____feeling panicky
_____diarrhea
_____shy with people
_____muscle twitching
_____nausea or vomiting
_____can't make decisions
_____can't make friends
_____headaches
_____fainting spells
_____unable to relax
_____feeling fearful
_____overly sensitive
_____anxious inside

_____money problems
_____relationship concerns
_____work difficulties
_____sexual problems
_____can't hold a job
_____excessive drinking
_____excessive medication use
_____depressed
_____excessive overeating
_____problems with parents
_____poor physical health
_____fighting and quarreling
_____dislike my body
_____full of energy
_____overly ambitious
_____easily excited
_____quick tempered
_____impatient with people
_____binge eating
_____very restless
_____feel like hurting someone
_____feel like smashing things

Please circle:

YES NO I acknowledge that I have read and understand all of the HIPAA regulations and statements and that my signature below indicates that I agree to abide by all of the above conditions.
YES NO I understand HIPPA policies, and have been offered a copy of HIPAA policies.
YES NO I authorize the release of any medical information necessary to process my insurance claims.
YES NO I authorize benefits to be paid directly to Kim T. Hoffman, Ph.D.
YES NO I consent to the exchange of treatment information with my primary care physician.

Physician's name/office and phone: ____

Is it okay to communicate electronically (email/fax) with those you sign a release (PCP, Psychiatrist, etc.)

No ______ Yes _____

Is it okay to communicate with you by email? No ______ Yes _____
Email address :___________________________

Signed:____ Date:___________________________

edit 11-2011