MaryEllen Agolia, Ph.D., LLC

P.O. Box 351
High Rolls, New Mexico 88325
(575) 430-4115

Intake Questionnaire

Client Information

Name: _____ Date: _____

Address: _____City:_____ State: _____ Zip:_____

Phone Number: _____ Cell Phone Number: _____

Social Security Number: _____-_____-_____ Gender: Male/ Female

Date of Birth: _____/_____/_____ Age: ____ **Is client under 18?** YES/ NO

Relationship Status: _____ Single _____ Married _____ Divorced
_____ Engaged _____ Separated _____ Widowed

Please List Those Living With Client: (including parent, guardian, siblings, and others)

	Name	Sex	Birth Date	Age	Relationship to Client
(1)					
(2)					
(3)					
(4)					

Spouse/Partner Name:_____

Spouse/Partner Address (if different): _____

Spouse/Partner Date of Birth: _____/_____/_____Spouse/Partner SS#: _____-_____-_____

EMERGENCY CONTACT NAME & PHONE #: _____
EMERGENCY CONTACT RELATIONSHIP TO CLIENT: _____

Insurance Information/Responsible Party

Name of Insured: _____ Insured's ID#: _____ Group#: _____

Insurance Company Name: _____
Insurance Company Address: _____
Phone Number: _____

Secondary Insurance? Yes/ No

***A copy of your insurance card(s) and driver's license/ID card is required.**

Educational History of Client

Is client currently a student? Yes/ No If so, where? _____

Education (check all that apply): ____ High School/GED _____College
____ Graduate School
____ Special Training (please describe) _____

Year of College/Training Graduation: _____ Name of School: _____

Work History of Client

Is client currently working?: Yes / No How long? _____Years _____Months

Employer Name/Company: _____ Current Position Held: _____
Work Address: _____ Work Phone #_____

Are you satisfied with your current employment?: Yes / No Any work related difficulties? Yes / No

Medical History of Client

Name of Physician: _____
Address of Physician: _____
Phone # of Physician: _____

May I contact physician in case of emergency? YES NO Signature: _____

Has client ever had any significant illnesses or medical problems? Please include any allergies, sensitivities, or other reactions to over the counter drugs, supplements, herbal remedies or prescriptions medications: YES/NO

If yes, please explain: _____

Please list any prescribed, over-the-counter and herbal medications client is taking:

1)_____ 3)_____

2) _____ 4)_____

Has client ever been in counseling before? Yes No

If so, where? _____ Name of Counselor: _____

Has client ever been hospitalized for mental health reasons? Yes No

If so, where and for how long?: _____

Has client ever been arrested or convicted of a crime? Yes No

Has client ever been addicted to alcohol, drugs, food, tobacco, gambling, sex, etc? Yes No

Has client ever had suicidal or homicidal ideation? Yes No
If so, has client ever attempted to harm self or others? Yes No

Mood of Client

Please circle what describes mood within the last 2-4 weeks:

Calm Sad Anxious Angry Happy Frustrated Worried Hopeless Helpless Up-And-Down

Other:_____

_____

Primary Concerns of Client or Guardian (CIRCLE ONE)

Briefly describe concerns/problems that initiated you decision to enter counseling.

1)_____

2)_____

3)_____

Goals of Client or Guardian (CIRCLE ONE)

What are your goals for counseling/what would you like to see change or become different in your life?

1)_____

2)_____

3)_____

Custody Status of Guardian(s) of Minor Child

Please list the current custody status of each guardian and list any primary caregivers with whom minor child spends time:

1)_____

2)_____

3)_____

Method of Payment:

Payment options (check one):

_____ Private Payment (Circle One: No Insurance Sliding Scale Fee Qualification)

_____ Provider files claim with my insurance for direct payment and I am responsible for my insurance deductible and/or co-payment at the time services are rendered. I understand that I am responsible for any balance not covered by insurance.

Office Policies:

1. All information you and your child bring to this office is confidential and will be released only with your written permission, except when the law requires otherwise. However, if you want your insurance claims to be filed, your signature below will give permission to release relevant information to your insurance company.

2. Payment is expected in full at the time of service unless otherwise arranged in advance.

3. I reserve the right not to extend credit to those who fail to pay upon receipt of statements.

4. I reserve the right to charge for any appointment missed with less than 24-hours notice of cancellation or rescheduling.

Consent for Treatment:

Client/Guardian has read and signed a separate *Consent for Treatment* which contains and explains policies and procedures of MaryEllen Agolia, PhD regarding: Informed Consent, Confidentiality, Children & Adolescents, Accessibility, Reasonable Expectations, and Coordination of Care.

Client/Guardian Signature: _____ Date: _____

I certify that the information given is true and correct to the best of my knowledge. I have read and understand the Office Policies and I understand that I am responsible for all charges incurred for services that I or my dependents receive.

Client/Guardian Signature: _____ Date: _____

Responsible Person Signature: _____ Date: _____

I hereby acknowledge that the statements contained herein and the information provided by me, the client or guardian, are true to the best of my knowledge and that I am responsible for updating my counselor of any change in circumstance including contact information, insurance information, and employment status, as this current information is necessary for accurate record keeping and claims processing:

_____ _____

Signature Date