vitalchanges
Science and Spirituality for Personal Transformation
David McFarlane, Ph.D.
5411 Renton Ave South, Seattle, Washington 98118
Phone 425-687-9600; Fax 425-264-0136
www.VitalChanges.org

CLIENT INTAKE FORM

CLIENT INFORMATION

NAME: ____________________________________ DATE: _________________

YOUR MAIN CONCERN: ____

____

____

Referred by: ____
VitalChanges.org web site; _____ Insurance web site; _____ Other
_______________________________________.

Date of Birth: _____________ Age: ____________ Gender: ___________________

Ethnic Identity: ____________________________ Languages: ____________________

Spirituality/religious affiliation: ____

Education: __________________________ Housing_____________________________

Are you in Crisis? Yes No

If yes, what is the crisis: ____

____

____

What is the outcome you like to see as a result of therapy? ________________________

____

____

Marital/Relationship Status:____
Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower

___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

___ Other (specify): ____

Sexual orientation: __________ Comments: ________________________

Sexual dysfunctions? ______Yes __________No________________________

If Yes, describe: ____

Any current or history as sexual perpetrator? ___ Yes __ No

If Yes, describe: ____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
____________________	________________	________________
____________________	________________	________________
____________________	________________	________________
____________________	________________	________________

Physical Heath

Name of Primary Care Physician: ___________________________________

May I contact your physician if necessary? Yes No ____________ [Please

initial] List any major health problems for which you currently receive treatment:

____

____

List any medications which you are now taking:

Current prescribed medications	Dose	Dates	Purpose	Side effects
__________________	_____	______	__________	___________
__________________	_____	______	__________	___________
__________________	_____	______	__________	___________
__________________	_____	______	__________	___________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
__________________	_____	______	__________	___________
__________________	_____	______	__________	___________
__________________	_____	______	__________	___________

Do you have any blood relatives with a history of mental emotional disorders? If so, please describe their conditions and any medications that they used and any difficulties they had._

____

____

Please check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: ___________________________

____

____

Chemical Use History

Name of Substance	Method of use	Frequency and amount	Age of first use	Age of last use	Used in last 48 hours	Used in last 30 days
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): ________
____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

____

____

____

PLEASE DESCRIBE YOUR CURRENT CONDITION [PAST 3-4 WEEKS] REGARDING:

FEELINGS OF SADNESS: ____

FEELINGS OF HOPELESSNESS: ____

FEELING LIFE IS WORTH LIVING: _____________________________________

FEELING THAT LIFE IS NOT WORTH LIVING: ___________________________

RELATIONSHIP CONFLICTS: ____

SUPPORTIVE RELATIONSHIPS: ____

EMPLOYMENT SATISFACTION: ____

PAST COUNSELING ISSUES: ____

VIOLENCE IN HOME: ____

PAST SEXUAL, EMOTIONAL, PHYSICAL ABUSE: _________________________

____

Billing Information

Client Name: ________________________________ Date of Birth: _______________

Address: ____

Home phone: ___________________ Work phone: _______________________

Cell phone: _____________________ Email: ____________________________
[√ Check preferred contact numbers]

INSURANCE COMPANY: ____

POLICY NUMBER:____________________ GROUP NUMBER: ________________

NAME OF INSURED: ____

SECONDARY INSURANCE COMPANY: __________________________________

POLICY NUMBER:____________________ GROUP NUMBER: ________________

NAME OF INSURED: ____

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.
I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: ______________________________ Date: ____/____/_____

Release of Information Authorization to Third Party

I (we) authorize **Vital Changes, Inc.** to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to **Vital Changes, Inc** .

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: ___________________________ Date: ____/____/_____

Person(s) receiving services: _______________________________ Date: ____/____/_____

Person(s) or guardian(s): ____________________________________ Date: ___/____/_____

____

Signature: ____ Date _____________