Naturally You Counseling Center
Mark Michalica, LMT, LPC

215 E. University Dr.
Denton, TX. 76209
940-484-6275

Adult Intake Form

Consumer Name

Address

City / State / Zip

(Ok to send correspondence to this address? Yes / No)

Home Phone Ok to leave a message here? Yes / No

Cell Phone Ok to leave a message here? Yes / No

Work Phone Ok to leave a message here? Yes / No

Email Ok to leave a message here? Yes / No

Birth Date

Marital Status ○ married ○ single ○ divorced ○ cohabitating

Occupation

How did I hear about Naturally You?
○ Internet search
○ Yellow pages
○ Friend
○ Relative
○ Referral
○ Other health professional
○ Facebook

Insurance Information

Insured name Birth Date

Insured employer SSN#

Insured co.

Insured member ID#

Insurance phone # (back of card)

Initial for Authorization (Client's with Insurance ONLY)

_____ Electronic submission is often a faster method to reimbursement. I understand that Naturally You is an Out-Of-Network provider in some cases, that will submit for insurance reimbursement upon my request.

_____ Should I authorize Naturally You to submit claims to my insurance company, I hereby authorize the release of any information relating to insurance claims, and I authorize payment of group insurance benefits directly to Naturally You, which may be used as credit for upcoming appointments.

_____ I understand that my insurance company may pay less than the actual bill for services, and that I am fully responsible for payment in full at the time of my appointment.

_____ I give consent to Naturally You to perform necessary procedures to diagnose, treat and care for the mental health needs for my child or me.

_____ I understand that all receipts will be mailed to my address given on the Intake Form, but that I can request a paper copy anytime

Payment Type.

How will you be paying for your sessions (circle one)

CASH ***CHECK*** ***VISA*** ***MASTERCARD*** ***AMERICAN EXPRESS***

If paying by credit card, please fill out the following:

Name on card. ____________________

Card number. ____________________

CVV code. ____________________

Card expiration date. ____________________

Authorized card signer. ____________________

Please describe the main problem for which you are seeking help

____

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Please indicate all symptoms you have recently been experiencing

- ○ persistent depressed mood, including feelings of sadness or emptiness
- ○ loss of interest or pleasure in activities or hobbies that were once enjoyed
- ○ decreased interest in sex / increased interest in sex
- ○ feelings of helplessness and pessimism
- ○ feelings of guilt, worthlessness and helplessness
- ○ sleep loss, difficulty falling asleep
- ○ too much sleep, oversleeping
- ○ loss of appetite
- ○ weight loss
- ○ increased appetite
- ○ weight gain
- ○ loss of energy/fatigue
- ○ slowing of thoughts
- ○ irritability
- ○ restlessness, nervousness, anxiety
- ○ panic attacks
- ○ difficulty concentrating, remembering and making decisions
- ○ headaches, chronic pain that does not respond to medical treatment
- ○ feeling unusually "high", euphoric or irritable
- ○ needing little sleep yet having great amounts of energy
- ○ talking so fast that others can't follow you
- ○ having racing or rapid thoughts
- ○ being so easily distracted that your attention shifts between many topics
- ○ having an inflated feeling or power, greatness, or importance
- ○ going on spending sprees

- ○ anger, aggressiveness
- ○ having ideas that are strange, false or out of touch with reality
- ○ hearing voices talking to you or saying negative things to you
- ○ seeing things that others do not see
- ○ experiencing ordinary things that appear frightening
- ○ disorganized speech and confused thinking
- ○ disorganized behavior (doing things that do not make sense to others)
- ○ history of self mutilation (cutting, burning, picking at skin, pulling of hair)

Current concerns: Check all those that apply (circle the most significant one)

- ○ Adjustment to life changes (school, divorce, moving, marriage, aging, aging, etc.)
- ○ Career dissatisfaction or decisions
- ○ Abuse (physical, emotional, sexual)
- ○ Disturbing memories (past abuse, neglect, or other traumatic experience)
- ○ Drug or alcohol use (past or present)
- ○ Eating problems (overeating, purging, restricting diet, bingeing, etc.)
- ○ Health concerns
- ○ Personal Growth
- ○ Significant other, spouse relationship
- ○ Parent-child relationship (discipline, adoption, single parent, etc.)
- ○ Family or step-family relationship
- ○ Non-family relations (roommates, friends, co-workers, boss, teacher, etc.)
- ○ Religious or spiritual concerns
- ○ Sexual functioning concerns
- ○ Sexual identity concerns
- ○ Sleep problems (nightmares, sleeping too much or too little, etc.)
- ○ Other (please explain)

____

____

____

Do you have current thoughts of harming yourself, suicide or death? Past attempts?

Do you have current thoughts of harming others? History of aggressive behavior?

When did you first become concerned about this problem?

What have you done in the past to deal with this issue?

Have you ever been treated for a mental health concern in the past (Counseling, Psychiatric, Hospital, etc.) Explain

Are you presently receiving medication for a mental health concern yes / no

Describe and list medications

Are you presently receiving medication for a physical health concern yes / no

Describe and list medications or any **HEALTH CONCERNS** you may have

Name and phone # of any physicians, psychiatrists you are now seeing

Present Family (current family in which you now reside)

name	age	gender	relationship to you

Family of Origin (family in which you resided the majority of your life)

name	age	gender	relationship to you

Mother's marital status

○ never married ○ married ○ divorced ○ separated ○ widowed

○ remarried ○ unknown number of marriages _____

Father's marital status

○ never married ○ married ○ divorced ○ separated ○ widowed

○ remarried ○ unknown number of marriages _____

Family History / Experiences

(Please indicate all that apply)

○ frequent moves ○ supportive ○ violent

○ physically-abusive ○ chaotic ○ strict

○ neglectful ○ punishing ○ loving

○ sexually-abusive ○ consistent ○ religious

○ few expectations ○ other ________________________________

Is there a history of learning, emotional, or behavioral problems in your family?

Is there a history of alcohol / drug us in your family?

Is there a history of violence / abuse in your family?

Is there a history of behavioral, emotional or mental problems in your family?

Is there a history of health problems in your family?

Do you currently participate in any recreational activities?

Do you currently have hobbies you participate in?

What are your GOALS for this counseling process?