This PDF allows for you to complete it electronically. Double click below the fields, type, complete, and print or email back to your therapist.

Thank you for selecting Gateway to Solutions. We look forward to creating a productive and rewarding relationship with you! Please print and bring the completed intake to your next appointment.

I. Contact Information

Name (First Last)

Today's Date:

Date of Birth: Age:

Physical Address:

Street *City, State, Zip Code*

Employer: Occupation:

Home Phone: Work: Cell:

Email:

II. Emergency Contact

Name: Relationship:

Physical Address:

Street *City, State, Zip Code*

Phone Number:

**The emergency contact person will only be contacted in accordance with the attached confidentiality agreement.*

III. Referrals

How did you hear about us?

Family member, name

Friend, name

Physician, name

Agency, name

Internet, what site

Print Advertisement, where

Are you looking for referrals for the following?

Couples Therapist

Family Therapist

Support group (please specify)

Outpatient substance use treatment

Divorce Mediator

Career Coach

Meditation/Yoga

Psychiatrist

Nutritionist

Internist/Primary Care Provider

Doctor specialist (please specify)

Acupuncturist

Gym Trainer

Accountant

Financial Advisor

Real Estate Broker

Lawyer (please specify)

Other (please specify)

IV. Presenting Problem

Please state in detail what brings you to therapy now

Please state your history of these areas of concern (i.e. when did they begin, have they changed and how since you first noticed them)

What do you hope to gain from therapy?

V. Health History

List any major physical illness, hospitalizations, accidents that you have had and at what age they occurred:

Have you had any past psychiatric hospitalizations? Yes No

If yes, please state when, where and reason for hospitalization

What prescribed medications do you take regularly, if any?

Medication	Dose	Frequency	Length Taken

Name of Primary Physician: Phone Number:

Physical Address:

Street *City, State, Zip Code*

When was the date of your last physical exam?

Name of Psychiatrist (if applicable): Phone Number:

Physical Address:

Street *City, State, Zip Code*

When was the date of you last appointment with your psychiatrist?

Have you ever been in therapy before?

Yes No

If so, what was your previous experience like? (i.e. What did you like and dislike about the experience)

What recreational substance have you used in the past, if any? (alcohol, marijuana, cigarettes, etc.)

What recreational substance do you currently use, if any? (alcohol, marijuana, cigarette, etc.)

How often do you use these substance (if not currently using, how often in the past)?

Do you consider any of your substance use to be a problem? Yes No

If yes, please describe

Do you currently have thoughts about suicide? Yes No

If yes, do you have a plan, please explain

Is there a history of suicide in your family? Yes No

If so, who?

Do you currently have thoughts about harming others? Yes No

If yes, do you have a plan, please explain

Do you engage in risky or self-injurious behaviors (cutting, dangerous sexual behaviors, etc.)

Yes No

If yes, please describe:

Do you or anyone in your household own a firearm? Yes No

If yes, please describe (type, how many, license, etc.)

Do you ever engage in any of the following impulsive behaviors?

Lying	Risky/Unsafe Sex
Excessive Spending	Hitting/Punching
Shoplifting	Other

If yes, please describe:

VI. Personal and Family History

Where were you born?

Please list the members of your current family, including ages and occupations. Please be sure to state if family members are biological, adoptive, or other

Are your parents married or divorced?

Married

Divorced

Other

If divorced, are either of them re-married?

Which of the following best describes your sexual orientation?

Gay	Bisexual	Asexual
Lesbian	Pansexual	Questioning
Straight	Queer	Other

Which of the following best describes your gender identity?

Female	Gender Fluid	Agender
Male	Bigender	Cis
Transgender	Intersex	Other

Which of the following applies to you? I am

Single	Partnered	Widowed
Married	Divorced	Other

I am in a serious relationship and we live together

I am in a serious relationship and we do not live together

I am monogamous

I am polygamous

Please list previous marriages and/or serious relationships.

Please answer the following if you are with your partner now:

What is your partner's name?:

What is your partner's occupation?:

Please list the names and ages of your children, if any, including step-children. Please note if your children are biological or adopted. If adopted, please note age adopted and from what country. If any of them are deceased, please list date they died:

Please check any past or impending issues that apply to you, your parents and/or your sibling(s)

	Self	Parent 1	Parent 2	Sibling(s)
Psychiatric Hospitalizations				
Anxiety				
Depression				
Schizophrenia				
Bipolar Disorder				
Attention Deficit/Hyperactivity				
Obsessive-Compulsive Disorder				
Personality Disorder				
Anorexia				
Bulimia				
Binge Eating Disorder				
Insomnia				
Attempted/Completed Suicide				
Emotional Abuse				
Physical Abuse				
Sexual Abuse				
Learning Problems				
Cancer				
Multiple Sclerosis				

	Self	Parent 1	Parent 2	Sibling(s)
Ulcers or Colitis				
Asthma				
HIV/AIDS				
Epilepsy				
Weight/Eating Problems				
Debilitating Injuries/Disabilities				
Numerous Childhood Illnesses				
Frequent Relocations				
Deaths				
Divorce				
Financial Crisis/Unemployment				
Legal Problems				
Alcohol/Substance Use				
Alcohol/Substance Use Treatment				

VII. Social Assessment, Work, Education, Current Living Situation

What is your ethnic identity?

Religious Preference?

Holiday Observances?

Social Activities?

Languages Spoken?

Hobbies?

Do you work at the present time?

Yes, full time	Student, part time
Yes, part time	Student, full time
No	Homemaker
Retired	Supporter by savings, family, etc.

If you are employed, where do you work?

What is the nature of your work?

How long have you been at your present job?

What were your previous jobs?

What is the highest grade of school or degree completed?

If you are a student, where do you attend school?

How do you typically structure your time/day?

Briefly describe your current living situation

Any past or current involvement with the legal system? Yes No
If yes, please explain

How much is your immediate family a source of emotional support for you?

None Little Somewhat Substantial Very Strong

Besides family members who do you count on right now for friendship or emotional support? (please name and note relationship to you)

Mood Disorder Questionnaire (MDQ)

The MDQ can help your therapist determine what type of mood disorder you may be experiencing.

Instructions: Please check one answer for each question.

Has there ever been a period of time when you were not your usual self and….

	YES	NO
You felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
You were so irritable that you shouted at people or started rights or arguments?		
You felt much more self-confident than usual?		
You got much less sleep than usual and found you didn't really miss it?		
You were much more talkative or spoke faster than usual?		
Thoughts raced through your head or you couldn't slow your mind down?		
You were so easily distracted by things around you that you had trouble concentrating or staying on track?		
You had much more energy than usual?		
You were much more active or did many more things than usual?		
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
You were much more interested in sex than usual?		
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
Spending money got you or your family intro trouble?		

If you checked "yes" to more than one of the above, have several of these ever happened during the same time period? Yes No

How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

No Problem Minor Problem Moderate Problem Serious Problem

- Adapted with permission from Robert M. A. Hirschfeld, M.D.

Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15)

During the *past 4 weeks,* how much have you been bothered by any of the following problems?	Not bothered at all	Bothered a little	Bothered a lot
Stomach pain			
Back pain			
Pain in your arms, legs, or joints (knees, hips, etc.)			
Menstrual cramps or other problems with your periods [Women only]			
Headaches			
Chest pain			
Dizziness			
Fainting spells			
Feeling your heart pound or race			
Shortness of breath			
Pain or problems during sexual intercourse			
Constipation, loose bowels, or diarrhea			
Nausea, gas, or indigestion			
Feeling tired or having low energy			
Trouble sleeping			

AUDIT Questionnaire

Questions	0	1	2	4	5	Enter Score
1. How Often do you have a drink containing alcohol	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
		If score to 1st question is zero, stop screening here				
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
		If the total score for Questions 1-3 is 5 points or higher for Men or 4 points or higher for Women, then continue				
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				TOTAL SCORE		

The Alcohol Use Disorders Identification Test (AUDIT) is used by permission from the World Health Organization.

Scores of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 are considered positive results.

Brief Patient Health Questionnaire (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please Answer every question to the best of your ability unless you are requested to skip a question.

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
i. Thoughts that you would be better off dead, or of hurting yourself in some way				

2. Questions about anxiety	NO	YES
a. In the last 4 weeks have you had an anxiety attack – suddenly feeling fear or panic		
If you checked "NO", go to question #3.		
b. Has this ever happened before?		
c. Do some of these attacks come suddenly out of the blue --- that is, in situations where you don't expect to be nervous or uncomfortable?		
d. Do these attacks bother you a lot or are you worried about having another attack?		
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?		

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

4. In the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Worrying about your health			
b. Your weight or how you look			
c. Little or no sexual desire or pleasure during sex			
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend			
e. The stress of taking care of children, parents, or other family members			
f. Stress at work outside of the home or at school			
g. Financial problems or worries			
h. Having no one to turn to when you have a problem			
i. Something bad that happened recently			
j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act			

5. In the last year have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? **NO** **YES**

6. What is the most stressful thing in your life right now?

7. Are you taking any medicine for anxiety, depression or stress? **NO** **YES**

8.

	Periods are unchanged	No periods because pregnant or recently gave birth	Periods have become irregular or changed in frequency, during or amount	No periods for at least a year	Having periods because taking hormone replacement (estrogen) therapy or oral contraception
a. Which best describes your menstrual periods?					

	NO (or does not apply)	**YES**
a. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?		
b. If YES: Do these problems go away by the end of your period?		
c. Have you given birth within the last 6 months?		
d. Have you had a miscarriage within the last 6 months?		
e. Are you having difficulty getting pregnant?		

Patients With Insurance

We are doing our best to verify your insurance coverage. However, you are ultimately responsible for knowing your out-of-network policy limitations, deductibles, co-payment amounts, etc… Please be sure that you call your insurance company to increase your awareness of your insurance limits and responsibilities. If you are unsure if your sessions will be covered we **strongly advise that you reschedule your sessions until you are sure about your coverage**. You will be responsible for any and all balances not covered by your insurance company.

Also, we must be notified PRIOR to treatment of any change or loss of coverage.

By signing this form I understand and agree to these terms.

Client: First, Last Name

Signature

Today's Date

Confidentiality Agreement

I understand and fully acknowledge this therapist's obligation to be sure that my safety and the safety of others are not at eminent harm. If acts of suicide, homicide, or other forms of irreversible and/or life threatening acts are to occur (have occurred) I, the undersigned, acknowledge this therapist obligation to report such instances to the relevant authorities for referral and/or immediate action. Examples of such harms include but are not limited to suicide attempts, murder, etc. I, the undersigned, understand that this agreement is in compliance with mental health code of ethics and laws.

I, the undersigned, agree to the above and understand that my safety and the safety of others is this therapist's first priority. I, the undersigned, give permission for this therapist to contact the "*Emergency Contact Person,"* that I have chosen, only in case of such emergencies. I have listed a contact person on the *Initial Consultation Intake Form*.

I release this therapist from any liabilities and/or legal action, in regards to client-therapist confidentiality, in the event that this therapist must contact relevant authorities and/or the designated *"Emergency Contact Person."*

***For minors ONLY**
I, the undersigned, understand that if I am under the age of 18, this therapist is obligated to contact a parent or legal guardian in the event of the previously mentioned situations. The *"Emergency Contact Person"* MUST be a parent or legal guardian.

Client: First, Last Name | Social Security Number

Signature | Today's Date

This "Consultation Agreement" has been verbally reviewed with the above-signed client (s).

Therapist | Today's Date

Payment for Services and Cancellation Agreement

1. Individual Therapy Sessions are 45 minutes. Couple and family therapy sessions are 1 hour. Employment and Mediation Sessions are 1 hour.
2. Payment in full is due at the end of each session.
3. Checks are **not** accepted.
4. Canceled appointments and "no-shows" with less than **two (2) days** notice will be charged the full session fee.
5. GTS reserves the right to terminate treatment for excessively cancelled and rescheduled appointments. The average client cancels/changes appointments three or less times in a year period.
6. If the patient's insurance company does not pay claims within 45 days of claim submission, the client will be charged the cost of each session unpaid by the insurance company.
7. This agreement is in effect for the duration of treatment and until the time of discharge.

I am aware that there is **no charge** if I cancel appointments with at least **two day's notice**.

I understand and agree to the above policies.

Client: First, Last Name

Signature

Today's Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
PRINT Cardholder Name (as shown on card): _____
Card Number: _____ **CVV Security Code**:_____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for rendered services . I agree to pay this charge according to my card member agreement. There is a full session charge for no show appointments and reschedules with less than 48 hours notice. I understand that my information will be saved to file for future transactions on my account.

_____ _____