INTAKE FORM/SOCIAL HISTORY QUESTIONNAIRE
（please print all information）

Name: _____ Date of birth: _____

Insurance Company: _____ Policy No.: _____
Name of the insured: _____ Relationship: _____
Date of birth of the insured:_____ Cell phone number_____
Address:_____ City_____ Province:_____
Postal code:_____

What are the concerns for which you are seeking
_____
_____

FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS:
[ ] NO [ ] YES
Explain:
_____
_____

Race/Cultural Information:
1. Race: _____
2. Language spoken: _____
3. Cultural Considerations: _____

MARITAL STATUS:
Total # of marriage: _____
Current marital status:
( ) married; ( ) never married; ( ) separated; ( ) divorced ( ) widowed; ( ) Remarried

If currently married (or living with a significant other), please provide the following information about partner or friend:
Name: _____ Age:_____
Length of relationship:_____ Occupation:_____
Workplace;_____

YOUR EDUCATIONAL INFORMATION:
[ ] High School [ ] Associate degree [ ] Bachelor degree [ ] Master [ ] doctorate
[ ] other:_____

EMPLOYMENT:
Name of present company or employer:
_____
Job title: _____ Length of time on job: _____
How do you get along with people at work (i.e. co-workers, supervisors, etc.):_____

YOUR ANNUAL FAMILY INCOME: [ ] UNDER $30,000 [ ] $31,000-60,000 [ ] $ 61,000-90,000
[ ] 91,000-120,000 [ ] $ 121,000-150,000 [ ] OVER 151,000

FAMILY HISOTRY: (please fill out even if they are deceased)
Mother's name: _____ Occupation: _____
Father's name: _____ Occupation: _____

Number of siblings: _____ Number of children: _____ Any children living at home? _____

Siblings:

NAME	AGE	SEX	OCCUPATION	HIGHEST GRADE EARNED

Children:

Name	Age	Sex	Occupation or grade	Lives at home	Natural or step-child

Other household members

Name	Age	Sex	Occupation or grade	Relationship to client

PHYSICAL HEALTH INFORMATION:
Primary Physician or other Practitioner:_____ Phone:_____

MEDICAL INFORMATION—PAST AND PRESENT: (Please check any applicable)
Please list all medications, including herbs and vitamins you are presently taking, or therapies you are presently undergoing: (please attach the medication list if there are more)

Name of Drug	Prescribed or not	Dosage	Frequency

Medication allergies:

_____

HEALTH PROBLEMS (Check applicable columns):

Problem	Not a concern	Past	Present	Family history
Allergies				
Eating disorder				
Asthma				
Ever LOC				
Diabetes				
Contagious disease s				
Heart diseases				
Liver disease, jaundice				
Hearing problems				
Ob/gyn problems				
Obesity				
Seizure/epilepsy				
Thyroid problems				
Ulcer				
Vision problems				
High/Low Blood Pressure				
High/Low Blood Sugar				

Migraine				
Chronic pain				

Any Comments:

_____

_____

NUTRITIONS

Generally good? [ ] Yes [ ] No

Explain: _____

Special diet?_____

SOCIAL LIFE

Describe your family and support system's strength:

_____

_____

Describe your recreational interests:

_____

Describe any relationship problems with friends/family/coworkers:

_____

Previous Counseling/Treatment Information:

Have you ever received counseling, drug or psychiatric services? [ ] Yes [ ] No

Where and when?

_____

Therapy goal(s)?

_____

Reason for termination:

_____

Contact information of the helping professional:

_____

SUBSTANCE USE:

How old were you when you had your first drink? _____

Do you use illegal or unprescribed drugs including alcohol? [ ] No [ ] Yes

Explain which drugs, amount and frequency:

_____

_____

Do you misuse prescription drugs? [ ] No [ ] Yes Explain: _____

Do you drink alcohol? [ ] No [ ] Yes if yes, how often per week? _____

Is drug or alcohol use an area of concern: [ ] No [ ] Yes Explain: _____

Has anyone ever expressed concern with your use of alcohol or other drugs? _____

Have you ever been to an AA or NA meeting? [ ] No [ ] Yes

Have you ever had a legal charge related to alcohol or other drug use? [ ] No [ ] Yes

Explain:

_____

Do you smoke cigarettes now? In the past? [ ] No [ ] Yes Explain time period, amount and frequency:

_____

ABUSE HISTORY
Have you experienced physical, sexual or emotional abuse? [ ] No [ ] Yes Explain: _____
_____

LEGAL HISTORY
Do you have any history of legal charges? [ ] No [ ] Yes Explain _____
Are you currently on probation or parole? [ ] No [ ] Yes Explain_____
Probation officer's contact information: _____
Is treatment court ordered? _____
Are you currently in a lawsuit? [ ] No [ ] Yes Explain: _____
Law professional's contact information:
_____
Have you ever had suicidal ideation, thoughts, plan? If yes, please describe:
_____

Is there anything else you consider important for us to know about yourself?
_____
_____
_____
_____
_____
_____

Name: _____ Signature:_____ Date:_____

Signature of psychologist reviewing_____ Credentials: _____ Date: _____

Service and Fee Agreement

Your Rights

You have the right to receive feedback about the Treating Provider's assessment of your (your family's or your child's) difficulties and the proposed non-coercive treatment as well as possible outcomes of treatment. Your therapist may provide you with information about additional available resources.

You have the right to terminate services from Neuro Wellness Institute at any time or to be provided with an explanation if your Treating provider terminates treatment.

You have the right to complete confidentiality regarding all case record information. Only under the five following exceptions will pertinent information be released: 1)you have signed a specific Release of Information form authorizing the exchange of information, 2) the professional perceives you (or your child) to be an imminent danger to yourself or others, 3) the professional becomes aware of suspected or actual child abuse or neglect, 4) an order from a Court of Record is entered, relinquishing the claim of privilege, or 5) the use of a collection agency or small claims court becomes necessary to pursue unpaid fees.

You have the right to file a Recipient Rights compliant with and to receive a response from the Director at 248-528-1688.

Your Responsibilities

I will pay for services at the time of my appointment and will also pay for charges not accepted by my insurance company of any reason (including but not limited to deductibles, missed appointment charges and late fee charges). Specially requested services such as letters, phone consultations (during or after hours), attendance at meetings (such as court or school related), will be billed directly to me at the rate of $40.00/$50.00 in 15 minutes units. This includes any preparation and/or travel time involved. A late fee of $25.00 per month will be applied to my account when fee balances reach on month past due (excluding fees billed to third party payers). The late fee is cumulative, i.e., a separate fee is applied each month. A $25.00 service charge will be applied to your account for any check retuned because of insufficient funds. Current fees for services are listed on the attached chart. Troy Wellness Center reserves the right to adjust rates as necessary without notice.

I agree to provide updated insurance information in a timely manner should my insurance, or conditions of my insurance change at any point. I agree to contact Troy Wellness Center and provide at least 24 hours notice in the event that I am unable to keep my appointment. Unkept appointments or appointments cancelled without 24 hours notice will be charged to me (insurances cannot be billed for missed appointments) at the rate of $60.00 per missed appointment. I understand that my case may be closed if I have not had contact with my therapist for over 30 days unless otherwise arranged.

Authorization for Insurance Billing

Troy Wellness Center may have contacted my insurance company for an explanation for my benefits. If the insurance company, or I myself have given TWC incorrect information, I accept responsibility for payment of any rejected insurance claims.

I authorize Troy Wellness Center to bill my insurance company for services rendered and that payment be made by the insurance company to Troy Wellness Center [ ] Yes [ ] No

I authorize Troy Wellness Center to release to my insurance company and its designated managed care company (if applicable) all information necessary to determine these benefits for related services. [ ] yes [ ] No

Consents and Agreements

I consent to the exchange of information between the TWC and my (my child's) physician/primary Care Provider, Dr. _____ for the purpose of coordination of care throughout the course of treatment through verbal, mailed or faxed correspondence of pertinent information regarding my (my child's) care. [ ] Yes [ ] No

I have been provided with a copy of my rights as a recipient of mental health services, and have been notified of how to contact the director for complaints. [ ] yes [ ] No

I consent to the possibility of receiving a three month post discharge follow up survey by phone or mail. [ ] Yes [ ] No

Client's name (please print)	Client's social security Number	Client's Birthdate	Date

Signature of client (or parent/guardian)	SSN of Parent/Guardian	Relationship to client	Date

Parent/Guardian's Name (please print)	Parent/Guardian's Birthdate	Signature of Witness/provider	Date