CROSSROADS
PSYCHOLOGICAL
ASSOCIATES

10784 HICKORY RIDGE ROAD • COLUMBIA, MD 20144-3646
PH. 410/964-0425 FAX 410/964-0515

Intake Questionnaire – Adult

Name _____ *Date of Birth*_____

1. Please provide a brief statement explaining why you have scheduled this appointment:

2. Have you previously attended therapy/counseling? Yes _____ No ____

Name of Provider _____ Dates of service _____

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3. Have you been diagnosed with a medical or neurological problem? Yes _____ No ____

If yes, please indicate the diagnosis (es)

_____

If yes, are you currently receiving services for this problem? Yes _____ No ____

4. Have you been hospitalized for psychiatric reasons? Yes _____ No ____

If yes, when _____ and where _____

Additional: when _____ and where _____

5. What *psychiatric* medications are you currently prescribed? None _____

Name of Medication	Dose	Compliant (Always, Sometimes, Rarely?)

6. What *non-psychiatric* medications are you prescribed at this time? None _____

Name of Medication	Dose	Compliant (Always, Sometimes, Rarely?)

7. What *psychiatric* medications have been prescribed in the past? None _____

Name of Medication	Dose	Dates	Why Prescription was Ended?

8. Please indicate with a 'check' those issues concerning you; you may use more than one check as a means of indicating the severity of the problem:

	Depression – sad, unhappy		Few friends
	Anxiety – nervous, worrying a lot		Anger
	Procrastination		Legal problems
	Work problems (i.e., dissatisfaction)		Poor concentration
	Work problems (i.e., unemployed)		Few interests
	Low self-esteem/lacks self-confidence		Victim of a violent crime or domestic abuse

	Physical complaints/medical problems		History of suicide attempt
	Quickly changing moods		Current Suicidal thoughts/attempts
	History or current drug/alcohol abuse		Dependent – Insufficient autonomy
	Inattentive – easily distracted		Recently divorced
	Easily irritated – grumpy a lot		Ongoing conflict with extended family
	Relationship/marriage problems		Unusual/bizarre behavior
	Financial problems		Poor social skills
	Disorganization		History of Emotional/Physical/Sexual Abuse
	Loss/death of someone close to you		Isolative – preferring to be alone
	Lack assertiveness skills		Loss (i.e., death in the family)
	Problems with parenting/child difficulties		Problems with regulating food or weight
	Problems with thinking (e.g., paranoid)		Cuts/burns or otherwise harms self
	Sexual Problem		

9. Demographic Information:

a. Marital status: Married Single Significant Other Divorced Widowed

b. Please indicate who resides is your home by name and relationship to you:

_____

_____

_____

_____

10. How did you hear about our practice? (optional)

_____ Friend/Family member : Name:

_____ Psychologist/Psychiatrist/Social Worker : Name:

_____ Pediatrician/Medical Doctor : Name:

_____ Other (please describe) _____

11. How did you hear about us? _____ (optional)

PLEASE PRINT CLEARLY

CLIENT INFORMATION: _____
last name *first* *middle initial*

ADDRESS_____
Street # *city* *state* *zip*

Phone: Home (_____) _____Work (____) _____ Cell # (____) _____

Email Address (Optional):_____ Preferred means to contact patient _____

MARITAL STATUS_____ GENDER_____ D.OB. _____/_____/_____ AGE_____

EMPLOYER/SCHOOL_____OCCUPATION/GRADE_____

REFERRED BY _____

If Patient is under 21 years of age, please complete the following for any information not already included above.
By providing this information, permission is given to Crossroads Psychological associates to contact the below named individuals.

Mother's Name_____DOB: _____ Father's Name_____DOB: _____

Address _____ Address _____

_____ _____

H (___) _____Cell (___) _____ H (____) _____Cell (____) _____

W (___) _____Employer: _____ W (____) _____ Employer: _____

Email Address (Optional):_____ Email Address (Optional):_____

I understand that unless other arrangements are made, ***all fees are due and payable at the time of service****. If in the event my account is turned over to a third party, I understand I'll be responsible for all collection fees, interest, court cost and attorney's fees. Insurance benefits will be filed as a courtesy and I agree to accept financial liability for all charges,* ***including missed appointments with less than 24 hours notice****. I authorize the release of any information necessary to process my insurance claims with my carrier. Any statement balance billed is due and payable upon receipt or a finance charge of 1.5% will be added monthly to the unpaid balance until the debt is discharged.*

GUARANTOR/PATIENT SIGNATURE: ***DATE:***

***If you want us to file for Insurance benefits as a courtesy on your behalf (benefits payable to the Insured), please provide your card and complete the following:**

(Who is the insured)? *(D.O.B.)* *SSN#* *(Relationship to patient)*

FOR OFFICE USE ONLY

CHART _____ DIAGNOSIS_____ FEE $_____ COPAY_____ THERAPIST_____

Assigned to patient ___Yes or ___No Cash Patient _____