INTAKE QUESTIONNAIRE - ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date:_____
IDENTIFYING INFORMATION (for individual receiving services)

Name:_____ Date of Birth: _____

Address: _____ Sex: _____
_____ Marital Status: _____
Home Phone: _____ Work Phone: ( ) _____
Social Security Number: _____ Household Income: $ _____
Who referred you to Moving
Forward Life Services? _____

Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/ African American
- ☐ Two or more races

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Language of Choice:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Other: _____

Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Christian
- ☐ No Affiliation
- ☐ Other: _____

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify? _____
If you have a disability does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: _____
If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial, or ethnic identity, please explain below:
_____
_____

PRESENTING PROBLEM (current situation and history)

1. What us the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family Problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-Confidence	l. Work related	r. Other (explain):

_____

_____

_____

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No
   If yes when, where and with whom? _____
   _____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

3. Please describe your current alcohol consumption: _____
   _____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?
   ☐ Yes ☐ No If yes, please describe the circumstances: _____
   _____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole): _____
_____
_____

CURRENT FAMILY INFORMATION:

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		☐ Yes ☐ No
Children:		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
Others Living in the Household:		

2. Military service: ☐ Yes ☐ No

3. Occupation: _____

4. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Please check the appropriate box if you have experienced any of these problems:

☐ Head Injury ☐ Convulsions or seizures ☐ Sleep Disturbances
☐ Memory Problems ☐ Extreme tiredness or weakness ☐ High blood pressure
☐ Eating Disorder ☐ Cancer ☐ Loss of consciousness
☐ Frequent or severe headaches

Have you had/or clear of COVID-19 ☐ Yes ☐ No

Please explain anything checked above: _____
_____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____
_____

GOALS

1. What are your strengths? _____
_____

2. What are your weaknesses? _____
_____

3. What goals would you like to see reached as a result of your involvement with Moving Forward Life Services?

_____
_____
_____
_____

4. How will you know when these goals have been reached?

_____
_____
_____
_____

Therapist Review

Signature: _____ Date: _____

MOVING FORWARD LIFE SERVICES, LLC Date: _____

FINANCIAL AGREEMENTS, POLICES, PROCEDURES AND CONSENTS

Fees

The fees for the initial sixty minutes session is $125.00, each additional fifty-minute session is $80.00, which is payable at the time of each appointment, unless other arrangements are made. You can make payment with cash, check, or credit/debit card.

Appointments, Cancellations and No-Shows

At the conclusion of your initial interview you and your counselor may agree to schedule for additional appointments. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. If you are unable to keep a scheduled appointment, you must notify the MFLS at least **24 HOURS** in advance to avoid having to pay for the canceled or missed appointment, In addition MFLS allows **3** times of **NO Call** or **NO Show Policy** to remove the client off the schedule due to none compliance to office policy. Insurance will not pay for missed appointments; therefore you are responsible to pay a minimum fee of $50.00 as contracted with MFLS.

INSURANCE INFORMATION

Primary Insurance Insured is: Self ☐ Spouse ☐ Child ☐ Other: ☐

Name/Date of Birth _____

Secondary Insurance Insured is: Self ☐ Spouse ☐ Child ☐ Other ☐

Name/Date Birth _____

Insurance

Although you are ultimately responsible for your fee, health insurance may pay a portion of the charge. At your request the MFLS office staff will contact your insurance company regarding the benefits for our services and will also file your claims.

If your annual deductible has been met it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the MFLS. If the deductible has not been met you will be responsible for paying the full fee until the deductible has been satisfied. Co-pays are due at the time of your session.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

The privacy of your Protected Health Information is very important. Please read thoroughly and sign this as notice of how your information may be used and disclosed and how you may access the information.

Moving Forward Life Services (MFLS) and its affiliates are required by applicable federal and state laws to maintain the privacy of your protected health information (PHI). PHI is information that may identify you and relates to your past, present, or future physical or mental health/condition and related health-care services. We will not use or disclose PHI without your written authorization – except as described in this notice.

We are required to give this notice about your privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect.

This notice took effect on September 1, 2006 and will remain in effect until replaced by the agency. We reserve the right to change our privacy practices and the terms of this notice at any time – provided such changes are permitted by applicable law. In the event, we make a material change in our privacy practice; we will change this notice and provide it to you.

MFLS uses and discloses protected information about you for treatment, payment, and healthcare/program operations as follows:

1) **In addition to our use of your PHI for treatment, payment, or healthcare/program operations you may give us** written authorization **to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time (except where required by Court-ordered services). You revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.**

2) **We may use or disclose your PHI to the referral source for purposes of** treatment **planning and coordination, reporting compliance/non-compliance issues, and referral to another additional service provider.**

3) **We may use or disclose your PHI to obtain** payment **for services we provide to you. This may include such activities as verification of coverage and billing/collection activities and related data processing.**

MFLS may use and disclose your PHI in connection with our healthcare program operations. This may include such activities as quality assessment and improvement activities, reviewing the competence and/or qualifications of healthcare/program professionals, evaluating provider performance, conducting training programs, and accreditation, certification, licensing and/or credentialing activities.

Helping People to Move Forward in Life
2362 Main Street. • Suite B • Tucker GA 30084
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As required by law, MFLS may use or disclose your PHI when we are required to do so by law – including judicial and administrative proceedings.

MFLS may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others – including, if we have good reason to believe that you are engaging in child abuse.

MFLS may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of PHI under certain circumstances

MFLS may use or disclose your PHI to provide you with appointment reminders or to advise you that you are at risk for program termination. Such activities may include voicemail messages and letters.

By signing below you acknowledge that you have read and understand the above statements regarding Moving Forward Life Services privacy practices and that you have received a copy of this HIPPA form.

Client Signature	Date
Client Signature	Date
Parent/Guardian Signature	Date

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