Angie Heath, LCSW
Clinical Conversations, Inc

5680 Peachtree Pkwy, Ste B
Peachtree Corners, GA 30092
470.299.1379

COUPLE/FAMILY INFORMATION FORM

CURRENT DATE:_____ REFERRED BY:_____

NAME:_____ PREFERRED NAME:_____

ADDRESS:_____ CITY:_____ZIP:_____

DOB/AGE:_____SOCIAL SEC #:_____

WORK PHONE:_____ EMAIL (OPTIONAL)_____

CELL PHONE:_____ RELIGION:_____

EMPLOYER OR SCHOOL
NAME:_____POSITION:_____

PHYSICIAN:_____ PHONE:_____

PSYCHIATRIST:_____ PHONE:_____

Mental Health
MEDICATION:_____

PARENT OR
PARTNER NAME:_____ PREFERRED NAME:_____

ADDRESS:_____ CITY:_____ZIP:_____

DOB/AGE:_____SOCIAL SEC #:_____

WORK PHONE:_____ EMAIL (OPTIONAL)_____

CELL PHONE:_____ RELIGION:_____

EMPLOYER OR SCHOOL
NAME:_____POSITION:_____

PHYSICIAN:_____ PHONE:_____

PSYCHIATRIST:_____ PHONE:_____

Mental Health
MEDICATION:_____

CHILDREN'S
NAME/AGES:_____

_____

_____

IF UTILIZING INSURANCE BENEFITS, PLEASE TURN PAGE OVER TO CONTINUE INTAKE FORM

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INSURANCE CO:_____INSURED'S ID NUMBER:_____

INSURANCE PHONE (for MH/Medical on back of card):_____ GROUP #:_____

If covered under spouse/parent's insurance:
PRIMARY COVERAGE'S NAME/ADDRESS:_____

INSURED'S DOB:_____ INSURED'S SOCIAL SEC #_____

INSURED'S
EMPLOYER:_____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I request the payment from my insurance company be made directly to Angie L. Heath, LCSW with Clinical Conversations, Inc or (if utilizing out of network benefits, request payment of benefits either to myself or to the party who accepts assignment below). I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____
Patient, Parent, or Legal Guardian

APPOINTMENT REMINDERS

You can receive an appointment reminder via text. This service is from Jituzu.com which is HIPAA compliant and I pay for this service for my clients. I will input the minimal information needed (such as just your full name) into their system along with your phone number. Would you like to receive appointment reminders?

_____ Yes _____ No. I'll remember my appointments on my own.

Shall we input the cell phone # from above or would you like reminders sent to another number? _____

The minimum protected health information explained above is waived by signing this form.

Signature: _____ Date: _____

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(ADULT) INTAKE QUESTIONAIRE

*Name :*_____ *Date:*_____

1. *How many days have you been unexpectedly absent or tardy from work/school in the last 30 days?*

_____

2. *Do you have any current or history of medical conditions/illnesses?*

_____

			Comments:
3. *Are you having difficulty sleeping or staying asleep?*	*YES*	*NO*	
4. *Have you moved in the last 2 years?*	*YES*	*NO*	
5. *Have you changed jobs in the last 2 years?*	*YES*	*NO*	
6. *Have you experienced a recent death of someone close?*	*YES*	*NO*	
7. *Have you or others been concerned about your alcohol or drug use?*	*YES*	*NO*	
8. *Do you starve yourself, or make yourself throw up?*	*YES*	*NO*	
9. *Are you very concerned about your weight?*	*YES*	*NO*	
10. *Do you self-injure?*	*YES*	*NO*	
11. *Do you have any suicide thoughts or past attempts?*	*YES*	*NO*	
12. *Do you have any thoughts about hurting others?*	*YES*	*NO*	
13. *Do you feel you are in danger of being hurt?*	*YES*	*NO*	
14. *Do you have extreme irritability or outbursts of anger?*	*YES*	*NO*	
15. *Do you have problems in your relationships with other people?*	*YES*	*NO*	
16. *Do you tend to act or speak before thinking (poor impulse control)?*	*YES*	*NO*	
17. *Do you have sexual concerns?*	*YES*	*NO*	
18. *Do you hate going to work?*	*YES*	*NO*	
19. *Are you experiencing financial problems?*	*YES*	*NO*	
20. *Have you had any legal problems?*	*YES*	*NO*	
21. *Do you have excessive fears, worries, or nervousness?*	*YES*	*NO*	
22. *Do you prefer not to participate in community or social activities?*	*YES*	*NO*	
23. *Have you lost hope that your problem can be resolved?*	*YES*	*NO*	
24. *Do you have very low or high energy?*	*YES*	*NO*	

Other issues needing to be discussed:

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CHILD INTAKE QUESTIONAIRE

*Name :*_____ *Date:*_____

To serve you better and to address any areas of concern, please circle your answer to each question below. Thank you for your cooperation.

1.How many days have you been unexpectedly absent or tardy from work/school in the last 30 days?

_____

2. Do you have any current or history of medical conditions/illnesses?

_____

Has your child (or if child answering, have you…)			*Comments:*
3. been very concerned about his/her weight?	*YES*	*NO*	
4. moved in the last 2 years?	*YES*	*NO*	
5. changed schools in the last 2 years?	*YES*	*NO*	
6. been disciplined at school in the last year?	*YES*	*NO*	
7. experienced a recent death of someone close?	*YES*	*NO*	
Does your child (or if child answering do you…)			
8. drink or use drugs?	*YES*	*NO*	
9. starve him/her, or make yourself throw up?	*YES*	*NO*	
10. self-injure?	*YES*	*NO*	
11. have any suicide thoughts or past attempts?	*YES*	*NO*	
12. have thoughts about hurting others?	*YES*	*NO*	
13. tend to act or speak before thinking (poor impulse control)?	*YES*	*NO*	
14. have problems in relationships with other people?	*YES*	*NO*	
15. have sexual acting out behaviors?	*YES*	*NO*	
16. have extreme irritability or outbursts of anger?	*YES*	*NO*	
17. have current or had any past trouble with the law?	*YES*	*NO*	
18. have excessive fears, worries, or nervousness?	*YES*	*NO*	
19. have difficulty falling or staying asleep?	*YES*	*NO*	
20. feel down on him/her, or have low self-esteem?	*YES*	*NO*	
21. have a short attention span?	*YES*	*NO*	
22. have very low or high energy?	*YES*	*NO*	

Other issues needing to be discussed: