This PDF Allows for you to complete it electronically. Just double click below the fields, type, complete, and print

Thank you for selecting Gateway to Solutions. We look forward to creative 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: S.S. #

Date of Birth: Age: ☐ Male ☐ Female

Physical Address:

Street *City, State, Zip code*

Home Phone Work: Cell:

E-mail:

Would you like this email used for administrative purposes such as billing and scheduling inquiries?

☐ yes ☐ no

Would you like to receive our quarterly newsletter?

☐ yes ☐ no

Employer: Occupation:

II. Emergency Contact

Name: Relationship to you

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. Referral Source

How did you hear about us?

- ☐ Family member, name
- ☐ Friend, name
- ☐ Physician, name
- ☐ Agency, name
- ☐ Internet, what site
- ☐ Print advertisement, where

IV. Presenting Problem

Please State In Detail What Brings You To Therapy Now

Please State Your History of These areas of concern (ie: when did they begin, have they changed and how since you first noticed them)

What Do You Hope To Gain From Treatment?

V. Health History

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

Have you had past psychiatric hospitalizations? ☐ Yes ☐ No
If yes, please state where and reason for hospitalization

What prescribed medications do you take regularly, if any? (Medication, Dose, Frequency, how long taken)

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?

**If applicable*

Name of Psychiatrist: Phone Number:

Physical Address:

Street *City, State, Zip code*

When was the date of your last physical exam?

Have you ever been in therapy before?

☐ yes ☐ no

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

What recreational substances do you use / have you used in past, if any? (alcohol, marijuana, cigarettes etc.)

How often do you use these substances (if not currently using, how often in 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

Do you currently have thoughts about harming others? ☐ Yes ☐ No
If yes, do you have a plan, please explains

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

☐ Yes ☐ No

If yes, please describe:

Do you ever lose control of your anger and act impulsively? ☐ Yes ☐ No
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?

Please check any past or impending issues that apply to you, your parents and/or siblings?

	Self	Parent 1	Parent 2	Sibling
Psychiatric Hospitalizations	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Bi-Polar	☐	☐	☐	☐
Attention Deficit/Hyperactivity	☐	☐	☐	☐
Obsessive-Compulsive Disorder	☐	☐	☐	☐
Personality Disorder	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐
Bulimia	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Binge Eating Disorder	☐	☐	☐	☐
Attempted/ Completed Suicide	☐	☐	☐	☐
Emotional Abuse	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐
Learning Problems	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐
Ulcers or Colitis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Weight/Eating Problems	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Debilitating Injuries/Disabilities	☐	☐	☐	☐
Numerous Childhood Illnesses	☐	☐	☐	☐
Frequent Relocations	☐	☐	☐	☐
Deaths	☐	☐	☐	☐
Divorce	☐	☐	☐	☐
Financial Crisis/Unemployment	☐	☐	☐	☐
Legal Problems	☐	☐	☐	☐

Which of the following applies to you?

I am ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ 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:

VII. Education, Work, Social Assessment and 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
- [ ] No
- [ ] Yes, Full or part time?
- [ ] Student, Full or part time?
- [ ] Homemaker
- [ ] Retired
- [ ] Supported 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 you 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)

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** by calling 1- 800-333-4116 for John Carnesecchi or 908-358-8941 for Jennifer Silvershein and simply leaving a message. The message will automatically be time and date stamped.

I understand and agree to the above policies.

Client: First, Last Name

Signature

Today's Date

Cancellation Policy

If you choose not to complete this form please note that payment for missed or cancelled sessions is due at the next scheduled sessions or within one week of the missed session, whichever comes first.

I have been advised that the behavioral health services performed by Gateway to Solutions, Inc. require a 48 hour cancellation notice. I understand that I am fully responsible for payment of these services. Insurance companies cannot be billed for missed or cancelled appointments.

Failure to cancel a scheduled appointment at least 48 hours in advance will result in a charge of the full fee for the session scheduled to the credit card below.

Date: Charge:

Signature:

Credit Card Type: ☐ VISA ☐ MASTERCARD

#

Expiration:

CV Code:

Name on the Credit Card:

Billing Address:

Street:

City: State: Zip Code: