Judith Moore, MA, MFT

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Adult Intake Questionnaire

Name of Client ____Date________________

Age _________ DOB ___________________ Social Security Number: _____________________________________
Address ____
Phone ____ May I leave a message on this phone? ______________
E-mail ____________________________________ Occupation____
Employer____
Educational level_____________________________________ Relationship status __________________________
Partner's Name ______________________________________ Occupation _______________________________
Names and ages of Children: ____
Names and ages of others in your household ____
Emergency contact information ____
What is the best way for me to contact you? ____
Referred by ____

Areas of Concern: Please write "P" or "C" for Past or Current/recent symptoms.

Headaches __________ Dizziness _________ Fainting _________ Fatigue ____________ Allergies ____________
Anxiety _________________Panic Attacks ___________Feel Tense _____ Hyperactivity _____ Impulsivity _____
Trauma __________Flashbacks _______ Distrust of Others ____
Decreased Appetite ______________________ Increased Appetite _____________________ Nausea _____________
Stomach Trouble ____ Anorexia/Purging __________________________ Weight Gain/Loss __________________
Bowel Disturbance ______ Frequent Urination ________ Blurred Vision _____________ Tics _________________
Insomnia _____ Increased Sleep ______ Decreased Need for Sleep ____ Nightmares _________________________
Sadness ____ No Interest ____ Isolation ____ Loneliness ____ Hopelessness ____ Feel Like Crying ____________
Feel Worthless _________________ Elevated Mood __________ Mood Swings _______Racing Thoughts _______
Sexual Dysfunction ______ Financial Problems __________ Relationship Issues ___________________________
Conflict Within Family ____ Can't Keep Friends __________
Verbal, Emotional, Physical, Sexual Abuse ____________________________ Victim of Violent Crime __________
Visual Hallucinations _____ Recent Smelling Things Others Don't Smell ________ Hearing Voices ____________
Paranoia _______ Obsessions _____ Excessive Checking, List-Making, Washing _______ Compulsions _________
Please explain ____
Anger ____________________________ Aggression _____ Please explain ___________________________________
____
Homicidal Thoughts ______ Please explain ____
____
Suicidal Actions/Thoughts ______ Please explain ____
____

Do you have any other conditions or symptoms it would be important for me to know about you?

Do you have any specific goals with regard to your treatment? Any concerns about treatment?

Psychological History

Have you ever received mental health treatment before? ____ When and for how long? ____________

What was the focus of treatment? ____________

What are some individual or relational problem areas for you? ____________

How have you attempted to deal with them in the past? Were your efforts successful? ____________

Have you ever undergone psychological testing? ______ If so, by whom? ____________

Have you ever been hospitalized for mental or emotional problems? ____________

When and for how long? ____________

Why were you hospitalized? ____________

Name of treating hospitals, doctors, therapists, addresses, telephone numbers (I will not contact these therapists without your written authorization): ____________

____________(Please continue on back of page)

Have you ever taken any medications for a mental or emotional condition? _____

What meds, when and for how long? ____________

Have you ever attempted suicide? _______ When? ____________

Describe the circumstances that led to that (those) attempt(s.) ____________

Are you currently having any suicidal thoughts? Please describe ____________

Medical History

Name, address, and telephone number of physician: ____________

Have you ever been diagnosed with a serious illness? Please describe____________

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. ____________

Do you have any medical conditions that may be affecting your mental health? ____________

Are you currently taking any prescription medications? ____ How long have you been on the medications? _______

Name of prescribing doctors, addresses, telephone numbers (I will not contact these doctors without your written

authorization): ____
____
Please describe your overall health today ____
____
Do you Smoke? And if so, how much: ____
Do you Drink Alcohol? And if so, how much/often: ____
Do you Take Drugs? And if so, how often and what kind: ____________________________________
Past drug experiences: ____
Have you ever been in a 12-step program? Please describe. ___________________________________
____

Family of Origin History

Please describe your family of origin, including names and ages of family members, and your relationships with them:
____
____
____

Other Information- Do not fill out if uncomfortable with any questions.

Please describe your spiritual identity/orientation. ______________________________________
Please describe your interests/hobbies ____
Are you now or have you ever been involved in a lawsuit? _______ Please describe: ____________________
____
Please feel free to include any other information that you believe is relevant to your mental health treatment: ______

____

Completed by: ____ Date: ______________________

I have been provided a statement of HIPPA regulations regarding the Privacy Act and the legal communication of private medical records on Judith Moore's website: **judymooremft.com**

Name ____ Date ____________________

I have been provided a statement of Patient's Rights and Responsibilities on Judith Moore's website: **judymooremft.com**

Financial Information:
How do you intend to pay for treatment? (Venmo, check, Insurance)
____

Private pay clients are billed at $150 per session paid at the time of service.

If planning to use health insurance:
Name of Insurance Company ____
Name of Primary Insured (if a parent or other) ____

Policy # ____
Tel. number on Ins. Card for Mental Health Services ____

Telephone Number of Insured____
Address of Insured____
Primary Insured's Social Security Number (for Optum only) ____
Primary Insured's DOB____
Is Authorization required? ______ If yes, Authorization # ____
Number of sessions allowed per year or per Authorization ____
Is there a deductible? __________ If yes, what is it per year ____
Is there a co-pay per session for which you are responsible? _______ How much per session? __________________

Insurance Assignment, Information Release and Consent to Treatment:
I, the undersigned, certify that **I have reviewed the attached treatment agreement and privacy policy**; give my consent to treatment and that I have insurance coverage with ______________________________ and **assign directly to Judith Moore, MFT** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance.** I hereby authorize the release of all information necessary to secure the authorization of services, insurance case audit and the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____ Date ________________

Responsible Party Signature ____ Date ________________

I understand that this is a contract for services rendered. If client does not give cancellation notice of 24 hours prior to appointment time, client is aware he/she/they will be responsible for payment of Judy Moore's full fee for service. By signing, you agree to pay $150 for any missed appointment unless Judy extends a courtesy fee of her contracted rate with your insurance company.

Please be advised that I do not write reports for Disability, Workman's Compensation, Divorce Cases or Child Custody Cases.

Due to Covid 19, all sessions are being conducted by Zoom, Face time or cell phone.

Name ____ Date ____________________