Tulsa Family Development Center
4520 S Harvard Ave, Suite 200C
Tulsa, OK 74135
Phone: 918-743-3224
Fax: 918-743-9623
Email: tulsafamilycontact@gmail.com

To help us get to know you, come of the issues you are dealing with and to provide you with the proper treatment, it is very important that we obtain detailed information regarding your current symptoms, mental health, medical and background history. Please answer ALL of the questions on the next few pages.

ADULT INTAKE FORM

NAME: _____ DATE: _____

DATE OF BIRTH _____ AGE: _____

MARITAL STATUS _____

GENDER _____

ADDRESS _____ CITY _____STATE ____ZIP_____

PHONE _____ EMAIL _____

WHO REFERRED YOU TO US TODAY? _____

INSURANCE _____

POLCYHOLDER _____ DATE OF BIRTH _____

PRIMARY CARE DOCTOR _____

REASON FOR TODAY'S VISIT _____

_____

_____

TOWN AND STATE YOU WERE BORN IN _____

TOWN AND STATE WHERE YOU WERE RAISED _____

WHO RAISED YOU? _____

DID YOUR PARENTS DIVORCE WHILE YOU WERE GROWING UP? _____
IF YES, how old were you when this occurred?_____

DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS: _____

_____

DESCRIBE YOUR RELATIONSHIP WITH YOUR SIBLINGS: _____

_____

OF BROTHERS ____ # OF SISTERS ____ I WAS # ____ IN THE BIRTH ORDER

DESCRIBE YOUR CHILDHOOD UPBRINGING/FAMILY EXPERIENCES IN A FEW WORDS:

_____

HAVE YOU SUFFERED ANY FORM OF THE FOLLOWING ABUSE:

EMOTIONAL: FROM AGE ____ TO ____
PHYSICAL: FROM AGE ____ TO ____
SEXUAL: FROM AGE ____ TO ____

DID YOU GRADUATE FROM HIGH SCHOOL? _____
DID YOU ATTEND COLLEGE? _____
ARE YOU CURRENTLY WORKING? WHERE? _____

Job duties and length of employment _____

MARTIAL HISTORY - # OF MARRIAGES: _____

1) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS
2) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS
3) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS

STATUS: Current marriage Divorced Widowed

DESCRIBE CURRENT PEER RELATIONSHIPS

DIFFICULTIES FORMING NEW FRIENDSHIPS/MEETING NEW PEOPLE?

HOW WOULD OTHER PEOPLE DESCRIBE YOU? _____

_____

HOBBIES/WAYS YOU RELAX AND/OR FIND ENJOYMENT? _____

_____

SUBSTANCE USE/ABUSE HISTORY

DO YOU CURRENTLY DRINK ALCOHOL? _____
If YES – How much per week and type of alcohol? _____

DO YOU CURRENTLY SMOKE CIGARETTES/VAPE? _____
If YES – How many cigarettes/packs per day? _____

DO YOU CURRENTLY USE ANY ILLICIT DRUGS? _____
If YES – List type of drug(s) _____

HAVE YOU EVER BEEN IN TROUBLE WITH THE LAW? _____

DO YOU HAVE ANY CURRENT PENDING LEGAL/CUSTODIAL CONFLICTS? _____

MENTAL HEALTH HISTORY

HAVE YOU EVER HAD OUTPATIENT TREATMENT BY A PSYCHIATRIST? _____
If YES – List the name of provider, length of treatment and problems addressed

_____

HAVE YOU EVER HAD OUTPATIENT PSYCHOTHERAPY OR COUNSELING? _____
If YES – List the name of provider, length of treatment and problems addressed

_____

HAVE YOU EVER COMPLETED A PSYCHOLOGICAL EVALUATION/TESTING? _____
If YES – List the name of provider, diagnosis, and date of service

_____

HAVE YOU EVER BEEN HOSPITALZED FOR PSYCHIATRIC REASONS? _____
If YES – List name of facility, year admitted, length of stay and problems addressed

_____

ANY HISTORY OF MENTAL HEALTH ISSUES AND/OR SUBSTANCE ABUSE IN FAMILY?
MOTHER YES NO _____
FATHER YES NO _____
SIBLINGS YES NO _____

ARE YOU CURRENTLY TAKING, OR HAVE YOU TAKEN, ANY MEDICATIONS FOR PSYCHOLOGICAL REASONS? _____
If Yes – Please list medications, time(s) per day, dosage and length of usage.
_____

_____

MEDICAL HISTORY

DO YOU HAVE ANY CHRONIC HEALTH CONDITIONS? _____
If YES – Please list (e.g., high blood pressure, diabetes etc.)

_____

_____

DO YOU HAVE ANY PROBLEMS WITH CHRONIC PAIN? _____
If YES – Rate your average pain level (1= Mild, 10=Severe)

1 2 3 4 5 6 7 8 9 10

ANY OTHER MEDICAL PROBLEMS OF INTEREST FOR YOUR MENTAL HEALTH TREATMENT?

CURRENT PROBLEMS:	NEVER	OCCS	OFTEN	VERY OFTEN
Physical appearance	_____	_____	_____	_____
Health problems	_____	_____	_____	_____
Physical pain or discomfort	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Racing heartbeat	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Dizziness, lightheaded, fainting	_____	_____	_____	_____
Confusion or disorientation	_____	_____	_____	_____
Anxious or nervous	_____	_____	_____	_____
Restless or on edge	_____	_____	_____	_____
Poor attention/concentration	_____	_____	_____	_____
Racing thoughts	_____	_____	_____	_____
Spending too much time organizing or planning tasks	_____	_____	_____	_____
Difficulty making decisions or completing tasks	_____	_____	_____	_____
Trouble getting a thought out of your head	_____	_____	_____	_____
Behavior you have to repeat for no reason	_____	_____	_____	_____
Trouble throwing things away	_____	_____	_____	_____
Mood swings, rapid changes in your feelings	_____	_____	_____	_____
Depression, sadness or feeling "down"	_____	_____	_____	_____
Memory problems	_____	_____	_____	_____
Easily fatigued	_____	_____	_____	_____
Increased or decreased appetite	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Loss of interest in pleasurable activities	_____	_____	_____	_____
Flat or reduced emotions	_____	_____	_____	_____
Negative thoughts	_____	_____	_____	_____
Unresponsive to praise or criticism	_____	_____	_____	_____
Loneliness	_____	_____	_____	_____
Feeling of hopelessness	_____	_____	_____	_____
Feeling inferior	_____	_____	_____	_____
Being easily influenced by others	_____	_____	_____	_____

Trouble being alone	_____	_____	_____	_____
Feeling distance or detached from others	_____	_____	_____	_____
Feeling different from others	_____	_____	_____	_____
Difficulty trusting others	_____	_____	_____	_____
Trouble having close friends	_____	_____	_____	_____
Feeling like no one likes you	_____	_____	_____	_____
Thoughts of harming yourself	_____	_____	_____	_____
Trouble controlling your temper or anger	_____	_____	_____	_____
Conflict with authority figures	_____	_____	_____	_____
Lying or stealing	_____	_____	_____	_____
Fire setting or other property destruction				

CURRENT PROBLEMS	NEVER	OCCS	OFTEN	VERY OFTEN
Unwanted impulses, urges or desires	_____	_____	_____	_____
Intrusive or unwanted thoughts or images	_____	_____	_____	_____
Thinking others want to harm you	_____	_____	_____	_____
Thoughts of harming someone else	_____	_____	_____	_____
Hearing voices that others do not hear	_____	_____	_____	_____
Seeing things that other people do not see	_____	_____	_____	_____
Repeated images of experiences of traumatic event(s)	_____	_____	_____	_____
Feeling out of touch or separate from your body	_____	_____	_____	_____
Confusion about who you are	_____	_____	_____	_____
Feeling that you have more than one personality	_____	_____	_____	_____
Eating, food, exercise or weight concerns	_____	_____	_____	_____
Drug or alcohol problems	_____	_____	_____	_____
Gambling	_____	_____	_____	_____
Work, job, school or career problems	_____	_____	_____	_____
Financial problems	_____	_____	_____	_____
Legal problems	_____	_____	_____	_____
Marriage, family or relationship problems	_____	_____	_____	_____
Sex related problems	_____	_____	_____	_____
Religious or spiritual problems	_____	_____	_____	_____

HOW LONG (days, weeks, months etc.) HAVE THE MAJORITY OF THESE PROBLEMS OCCURRED?

_____

Tulsa Family Development Center

Financial Policy

We intend to provide you with the best quality treatment and business processed for your care. The following information will help you and our office work cooperatively to achieve this goal.

Our Responsibility

Insurance Verification and Estimating the Cost of Services

As a free courtesy to you, we will verify your insurance coverage. We will estimate as closely as possible your coverage, but until we actually receive a from your insurance company, it is only an estimate.

Filing Claims with your Insurance Company

We will file claims with your insurance company. We will provide documentation to your insurance company for claims processing. If they require additional information, we will provide them whatever is necessary to process the claim to maximize your insurance coverage.

Your Responsibility

If Your Insurance Does Not Cover Services

If your insurance does not pay for the services or if we are out of network with your insurance, **you** are responsible for the full payment at the time services are provided. Unless prior arrangements have been made.

Co-Payments, Co-Insurance and Deductibles

Co-pays or Co-insurance is due at the time of service. If your child attends an appointment alone, the payment is due at that time. For your convenience we ask that you put a credit card on file.

Change in Insurance Coverage

If you change insurance during the course of your treatment, it is **your** responsibility to notify us before your next appointment so your insurance can be verified.

Late Cancellations and No Shows for Appointments

We understand that things occasionally arise at the last minute and we make every effort to consider that. However, it is the **policy of this office to charge $125 for missed appointments and no shows. Please call to cancel 24 prior to your appointment.**

Account Balances

We will assist in working with your insurance for payment of the claims but the ultimate responsibility for payment belongs to you. After 60 days, any remaining balance not covered by insurance will be due in full.

Forms and Letters

Requests for letters and completion of forms are rapidly increasing and have thus become very time consuming and costly. Charges for detailed letters and form will be at the professional's hourly rate based on the time involved in preparation.

My signature below indicates that I have read and understood the Financial Policy of TFDC and I authorize the release of medical information to process insurance claims and I authorize payment of medical benefits to Tulsa Family Development Center.

Signature _____ Date _____

TULSA FAMILY DEVELOPMENT CENTER

CONSTENT TO USE AND DISCLOSE YOUR PROCTECTED HEALTH INFORMATION AND CONFIDENTIALY AGREEMENT

This form is an agreement between you and Tulsa Family Development Center. When we use the word "you" below, it will mean you as the client or you as the parent guardian, or personal representative of a child.

When we examine, diagnose, treat or refer you to another health professional, we will be collecting what the law calls your Protected Health Information (PHI). We need to use this information in our office to decide what treatments are best for you. We may also share this information with others who provide treatment to you or need to arrange payment for your treatment or other business or government functions. **Release of psychological information will specifically require your signed authorization.**

By signing this form, you are agreeing to let us use your information in this office and sent it to others, **with your permission**. Our Notice of Privacy Practices explain your rights in more details and how we and share your information.

As a client seeing a psychologist, one of your most important rights involves confidentially. Within certain limits, information revealed to you and /or your child during counseling or testing will be kept strictly confidential and will not be revealed to any other person or agency with your written permission. These limits to confidentiality are as follows:

1. If a client threatens a grave bodily harm or death to another person, a psychologist may be required to inform appropriate legal authorities and the intended victim.
2. If a client expresses a serious intent to grievously harm her/himself, it may be necessary for a psychologist to reveal information to family members and/or persons authorized to respond to such emergencies in order to protect the client from harm.
3. If a client is being evaluated or treated in response to a court order, the results of the evaluation or treatment ordered must be revealed to the court.
4. If a court of law issues a court order signed by a judge, the psychologist is required to provide information specifically requested in the court order.
5. If a psychologist has a good reason to suspect that a child is a victim of physical abuse, sexual abuse, or neglect, he/she is required to report the abuse or neglect to the appropriate authority.
6. If insurance companies involved in third party payment request reports including diagnosis, recommendations, and/or chart notes, this information must be provided.

Please be assured that the professionals at TFDC take your confidentiality very seriously and will make every effort to safeguard it.

I understand the limits of confidentiality as outlined above and hereby give my content for treatment. Also, by signing this form, you are agreeing to let us use your information in this office and send it to others.

_____

Date Signature of Client or Personal Representative

PLEASE

FILL OUT THE FORM BELOW

FOR CONTACTLESS PAYMENT

CONTACTLESS PAYMENT CONSENT

Patient Name_____

Parent/Guardian (If Applicable) _____

Credit Card #_____

Expiration Date_____ Security Code_____

Authorized Signature_____ Date_____