Karen Cross PhD
Clinical Psychologist
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858-229-1282

INTAKE FORM

PERSONAL INFORMATION

Client _____

Street _____

City & State _____ Zip _____

Phone (H) _____(W) _____

Cell

RESPONSIBLE PARTY (IF DIFFERENT)

Responsible Party _____

Street _____

City & State _____ Zip _____

Phone (H) _____(W) _____

PRIMARY INSURANCE

Policy Holder _____

Street _____

City & State _____ Zip _____

Insurance Company _____

Street _____

City & State _____ Zip _____

Phone _____

Member # _____

Group # _____

Employer _____

Street _____

City & State _____ Zip _____

SECONDARY INSURANCE

Policy Holder _____

Street _____

City & State _____Zip _____

Insurance Company _____

Street _____

City & State _____Zip _____

Phone _____

Member # _____

Group # _____

Employer _____

Street _____

City & State _____Zip _____

FAMILY INFORMATION

	M/F	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Client:					
Spouse/Partner:					
Children/Step-Children/Siblings:					
1					
2.					
3.					
4.					

MEDICAL INFORMATION

Physician _____

Describe any health problems _____

What medications do you take? _____

What serious illnesses have you had? _____

List any prior surgeries _____

Have you had prior counseling or therapy? When? _____

What was the concern? _____

Who was your counselor? _____

Have you ever been hospitalized for psychiatric treatment? When? _____

Where were you hospitalized? _____ For how long? _____

What brings you to counseling now? _____

How long have your current problems existed? _____

Describe your present concerns:

Where did you get my name? _____

Emergency Contact Person _____
(Name) (Relationship) (Phone)

PLEASE CHECK ALL THAT APPLY:

- ☐ crying spells
- ☐ unable to have fun
- ☐ feelings easily hurt
- ☐ lacking in confidence
- ☐ constipation
- ☐ feeling grouchy
- ☐ always tired
- ☐ poor appetite
- ☐ depressed
- ☐ trouble sleeping
- ☐ feeling lonely
- ☐ loss of weight
- ☐ not enjoying things
- ☐ suicidal thoughts
- ☐ feeling inferior
- ☐ loss of sexual interest
- ☐ no one understands me
- ☐ worried about health
- ☐ can't concentrate
- ☐ can't "get going"
- ☐ feeling angry
- ☐ don't like being alone
- ☐ lack energy
- ☐ fast heartbeat
- ☐ always worried
- ☐ frequent sweating
- ☐ dizziness
- ☐ shaky hands
- ☐ stomach trouble
- ☐ nightmares
- ☐ feeling tense
- ☐ cold feet and hands
- ☐ feeling panicky
- ☐ diarrhea
- ☐ shy with people
- ☐ muscle twitching
- ☐ nausea or vomiting
- ☐ can't make decisions
- ☐ can't make friends
- ☐ headaches
- ☐ fainting spells
- ☐ unable to relax
- ☐ feeling fearful
- ☐ overly sensitive
- ☐ anxious inside
- ☐ weight gain
- ☐ money problems
- ☐ relationship concerns
- ☐ work difficulties
- ☐ sexual problems
- ☐ can't hold a job
- ☐ excessive drinking
- ☐ excessive medication use
- ☐ excessive drug use
- ☐ problems with children
- ☐ problems with parents
- ☐ poor physical health
- ☐ fighting and quarreling
- ☐ dislike my body
- ☐ full of energy
- ☐ overly ambitious
- ☐ easily excited
- ☐ quick tempered
- ☐ impatient with people
- ☐ binge eating
- ☐ very restless
- ☐ feel like hurting someone
- ☐ feel like smashing things
- ☐ excessive overeating

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I welcome you to counseling and look forward to working with you. I believe the following information will be helpful in establishing a good therapy relationship between us. Please read this information carefully, and ask any questions that you have. When you have read both pages, please sign the statement on the back.

Initial Appointment Your initial appointment is considered a diagnostic interview. From the information you share on this first visit, we will decide together whether I am the right therapist to help you attain your goals. If we decide to work together, we will discuss the type of therapy needed (individual, group, medication, etc.), the frequency of therapy sessions (weekly, bi-weekly, etc.), and schedule your next appointments.

Appointments All appointments are scheduled directly with me, in person or by phone. If you find that you need to cancel an appointment, please give as much notice as possible. You will be personally charged for appointments not canceled at least 24 hours in advance, except for emergency reasons. Insurance companies do not pay for unattended appointments.

Payments The fee for your initial visit is $180 and for each therapy session thereafter is $175. Most insurance companies will pay for a portion of outpatient mental health services. With your approval by signature, I will bill your insurance company, and have the payments sent directly to me. You will be responsible for paying all deductibles and co-pays in full at each visit by cash or check. Because payment for your services is ultimately your financial responsibility, you should check carefully with your insurance company to find out the specific requirements of your coverage.

Confidentiality All information regarding the specific nature of your therapy is considered confidential, unless specified by you in writing.

Therapists are required by law to break confidentiality and warn person(s) when a client behaves in such a way that poses a threat of physical harm to another person or to self. California law also requires professionals to report suspected incidents of child abuse or neglect to the proper protective service agency.

Termination As you reach your goals in therapy, a gradual tapering of sessions will occur. It is helpful for you to discuss your wish to end counseling at least one or two sessions prior to your last session. A final session to process your therapy, settle any unfinished concerns, and say goodbye has proven to be beneficial.

Emergencies My confidential voicemail (858-229-1282) is always available for leaving messages when I am in session or out of the office. If an emergency arises when I am not available to speak with you, please call the HelpLine (1-800-479-3339), which provides 24-hour crisis intervention services. The emergency room of the closest hospital is also another resource in time of crisis.

I encourage you to ask any questions you may have concerning the above policies, either now or as they occur.

Please select:

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

I have received and thoroughly reviewed a copy of this intake form.

I authorize the release of any medical information necessary to process my insurance claims.

I authorize benefits to be paid directly to Karen Cross PhD.

I consent to the exchange of treatment information between Karen Cross PhD and my primary care physician.

_____
(Physician's name/office and phone number)

DATE _____ SIGNED _____