BIA
BEHAVIORAL INSTITUTE OF ATLANTA LLC
Because Change is Possible at Any Age
6000 Lake Forrest Drive, Atlanta, GA 30328 (404) 256-9325

ADULT INTAKE QUESTIONNAIRE

Name: ______________________________ Today's Date: ____________

Age: ____________ Date of Birth: __________________

Address: ____

____

Home phone: ________________________ Ok to leave message? Yes No

Work phone: ________________________ Ok to leave message? Yes No

Cell phone: ________________________ Ok to leave message? Yes No

Email: ____

Referred by: ____

May we acknowledge the referral? ______________

Reason you are seeking services:

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Present psychological difficulties – please check any that apply to you at this time.

_____ Generalized Anxiety (across many situations)
_____ Specific fears/phobias (list): ____
_____ Panic attacks
_____ Social Anxiety
_____ Obsessive thinking or compulsive behaviors
_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
_____ Sadness or Depression
_____ Emotionally overwhelmed
_____ Frequent crying
_____ Loss of energy
_____ Loss of pleasure in life
_____ Self-injurious / Self-harm behavior
_____ Thoughts of suicide
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of the night waking or early morning waking)
_____ Trouble waking up
_____ Fatigue/tiredness during the day
_____ Nightmares
_____ Problems with attention or concentration
_____ Racing thoughts
_____ Problems making or keeping friends
_____ Problems controlling temper
_____ Relationship/Marriage problems
_____ Problems with intimacy
_____ Problems with job
_____ History of abuse (emotional, physical, sexual)
_____ Alcohol/drug use/abuse
_____ Financial problems
_____ Legal situation

Other:

____

____

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

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What do you wish to accomplish (what are your goals) in seeking services at this time?

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FAMILY INFORMATION:

Marital Status (circle one):

Single   Living with Partner   Married   Separated   Divorced   Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good   ___ good   ____ fair   _____ poor   ____ very poor

Your occupation: ____

Occupation of Spouse/Partner: ____

Children and ages:

____

____

____

If divorced, what are the custody arrangements?

____

____

____

Who currently resides in your home?

____

____

GENERAL HEALTH:

Your current health: _______ excellent _______ good ______ fair _______ poor

Primary Physician's name/address/phone number:

____

____

____

When was your last physical exam? Any relevant findings?

____

____

Are there any other physicians you see on a regular basis?

____

____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

____

____

____

____

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

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Any problems with sleep? Describe.

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____

Any problems with eating? Describe.

____

____

Please rate the overall level of stress in your life:

_____Very Low _____Low _____Average _____High _____Very High

What do you consider to be the greatest source of stress at this time?

____

____

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). ________

Are you a past or present smoker?_______

Length of time, number of cigarettes and frequency: ____

Do you use alcohol? ______

Number of drinks and frequency: ____

Do you drink caffeinated beverages? ______

Number of drinks and frequency:____

FAMILY HISTORY:

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
_______	Mental Retardation	____________________________
_______	Speech or Communication Disorder	____________________________
_______	Attention-Deficit / Hyperactivity / Impulsivity	____________________________
_______	Learning Problems / Disabilities	____________________________
_______	Autism Spectrum / Asperger's Disorder	____________________________
_______	Sleep disorders	____________________________
_______	Generalized Anxiety (across many situations)	____________________________
_______	Social Anxiety	____________________________
_______	Obsessive-Compulsive Disorder	____________________________
_______	Phobias	____________________________
_______	Depression	____________________________
_______	Manic-Depression / Bipolar Disorder	____________________________
_______	Suicide attempts / Suicide	____________________________
_______	Schizophrenia or other psychosis	____________________________
_______	Alcohol / Substance Abuse	____________________________
_______	Seizures or other neurological disorder	____________________________
_______	Genetic Disorder (e.g., Down Syndrome, Fragile X)	____________________________

Other:

____

____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

____

____

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____

EDUCATIONAL HISTORY:

Your highest level of education completed: ______________________________

Any problems with attention, learning, or behavior in school?

____

____

____

Grades repeated and reason:

____

____

____

Served in Special Education?

____

____

____

Additional Comments:

____

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LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

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NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff are not available, please call your therapist's extension and either leave a message or contact him/her through their cell phone or pager. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

If your doctor/therapist is out of town or unavailable for some other reason, one of our other doctors/therapists will be on-call.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by either your doctor/therapist or our office staff.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your doctor/therapist will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need. **Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit.** In addition, because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your therapist's voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered. Any other arrangement is considered a special arrangement and must be discussed in advance with your therapist. Delinquent accounts may be referred to a collection agency.

We accept checks, Visa, and Mastercard.

For some therapists, collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim. Additional copies can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: ____________________

____
Client's Name

____
Client's Signature

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by ______________________________.
(BIA clinician)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold ______________________________ harmless for releasing information under the above conditions.
(BIA clinician)

Client's Name: ____ Date of birth: ________________

Signature: ____ Date: ______________________

PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby authorize ______________________________to release and discuss the results of my
(BIA clinician)

____ Psychological Evaluation/Testing

____ Treatment/Therapy

with the following individuals. I also give those listed below my permission to discuss and release

information regarding my care to ________________________________.
(BIA clinician)

This release of information is valid from ________________(date) to __________________ (date).

	Individual	Agency	Phone Number
1.	______________________	______________________	________________
2.	______________________	______________________	________________
3.	______________________	______________________	________________
4.	______________________	______________________	________________

Client name (print): ___________________________ Date of birth: _____________

Signature: __________________________________ Date: ____________________