Joseph C. Mallet, Psy.D.
Pediatric • Adolescent • Family Psychology

ADULT

New Client Intake Form

_______ - _________
Today's Date

Patient Name:
(Last)____(First)____________________(MI):_______

Age:_________Birthdate:___________________Gender: M / F

Address:____City:_______State:_____Zip:__________

Phone: (Hm):___________________(Wk): ____________________(Cell/Pager):______________

Partner/Spouse
(Last)_____________________________________(First)_______________________(MI)_______

Age:_________Birthdate:_____________________Gender: M / F

Address:____City:_______State:_____Zip:__________

Phone: (Hm):___________________(Wk): ____________________(Cell/Pager):______________

PHONE NUMBERS:
Other Contact Person: (Name)_______________________________(Relationship)______________

(Home)_________________ (Work):_______________________ (Cell/Pager):________________

E-Mail Addresses:________________________________ _________________________________

Your Employer:__________________________________Occupation:____________________

Spouse/Partner's
Employer:____Occupation:____________________

Reason for Visit:____

Who referred you to this office:____

How would you describe your current mental state? (Circle all that apply)

Calm	Happy	Nervous	Scared	Unmotivated	Regretful
Tense	Worried	Fearful	Sad	Disappointed	Confused
Irritated	Restless	Angry	Guilt Feelings	Other___________________	

MEDICAL HISTORY

Primary care physician's name:____
Date of last medical checkup:_________________ Was bloodwork completed? **Yes/No**
What were the findings? ____
Do you currently smoke cigarettes? **Yes No** If yes, list frequency_________________________

Hospitalizations, serious illnesses and/or injuries (list date(s) and describe):____________________
____

Please list any medications you are taking and for what conditions/reasons:
____
____

How many **Hours** of sleep usually?____

Quality/Characteristics of Sleep? Sleep is … -**Good** **-Poor** **-Disrupted**

Difficult Falling Asleep **Difficulty Staying Asleep** **Early Waking**

Wake up easily and rested in morning? Y/N Explain:_______________________

MARITAL HISTORY

Married **Single** **Divorced**

Name of spouse/significant other:____

Age: _________Is this your first marriage: **Yes** **No** **N/A** Years Married/Years together____

Briefly describe your relationship with your spouse/significant other:

FAMILY HISTORY

Children (if any):
Name:____ Age: _____________
Name:____ Age: _____________
Name:____ Age: _____________
Name:____ Age: _____________

Your father's name:___________________________Age:_________Living:_______Deceased:___
Your mother's name:__________________________Age:_________Living:_______Deceased:___

If parent(s) is/are deceased, how old were you when this occurred?:_________________________
Number of years parents are/were married:____
If divorced, how old were you when parents divorced:____________________________________
Briefly describe your relationship with your parent(s):____________________________________

Siblings (brothers/sisters):
Name:____ Age: _____________
Name:____ Age: _____________
Name:____ Age: _____________
Name:____ Age: _____________
Name:____ Age: _____________

DEVELOPMENTAL HISTORY

Any Known Developmental Delays or problems in Childhood?______________________________
Describe:____

If you were born in another country, how old were you when you moved to the U.S.?

Academic history: **Excellent** **Average** **Poor**

If poor, explain: ____

Highest level of education (grade/degree)? Religion primarily raised in:

MENTAL HEALTH HISTORY

Previous Psychotherapy/Counseling? **No** **Yes** If yes, list date(s) and name of therapist/agency: ____
Previous Psychiatric Treatment? **No** **Yes** If yes, list date(s): ______________________________
Psychiatric medication taken currently or in the past? **No** **Yes**
If yes, date(s) and what kind? ____
____
Have you ever been hospitalized for mental health reasons? **No** **Yes**
If yes, list date(s) and place: ____
History of suicidal thoughts or threats: **No** **Yes** If yes, date(s)
Suicidal gestures and/or attempts: **No** **Yes** If yes, explain ______________________________
____

History of physical abuse or assault: **No** **Yes** If yes, date(s):____________________________
History of sexual abuse or assault: **No** **Yes** If yes, date (s) ____________________________
History of arrest: **No** **Yes** If yes, explain: ____________________________
____
History of incarceration: **No** **Yes** If yes, explain:
____

History of involvement in lawsuits: **No** **Yes** If yes, explain:____________________________

Have you ever received treatment for alcohol and/or drug use? **No** **Yes** If yes, please specify dates and type of treatment:____

History of using alcohol or drugs? **No** **Yes** If yes, specify substance, quantity and when was the last time you used substance?

Are you currently using alcohol or drugs? **No** **Yes** If yes, specify substance, quantity, and frequency of use

Family history of substance abuse and/or mental illness?

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Patient Payment Responsibility Agreement Authorizations

Patient's Name:____Birthdate: ______________

Consent to Treat
I/We, (name of patient/and Spouse or Partner)_________________________, hereby authorize Dr. Joseph C. Mallet, Psychologist, to provide psychological evaluation and/or treatment as deemed warranted following our initial consultation.

(Patient Signature)____Date______________

(Spouse/Partner Signature)____Date______________

Initial Each Below:

_________I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment is due at the time services are rendered unless special arrangements have been made. Length of time for therapy sessions are 1.25 hour for an initial consultation at a rate of $250.00 and 50 minutes for follow-up sessions a rate of $190/hour or part thereof. Psychological testing services are billed at $250/hour.

_________In order to be flexible and responsive, I am available for phone sessions and to speak with you at times when necessary. Please be advised, however, that all calls exceeding **ten minutes** will be billed in a pro-rated fashion on the basis of your session fee.

_________I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and Dr. Mallet will always discuss additional charges with you. Other professional services include extended contact via email, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

________Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment late cancellation fee of $100. We may make exceptions and waive the fee, at our discretion, for emergency or unusual circumstances.

_________ I have received and understand the limits of confidentiality as discussed with Dr. Mallet.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature:____________________________________**Partner/Spouse** (if Applicable)__________________________

Printed Name:_________________________________ / ____

Date:_______________________________________