ADULT INTAKE FORM

Name: ______________________________ SS#: ________________ Date: ____________

Home Address: ____

City: ____ Zip Code: __________________

Home Phone: _______________________ Work Phone:

____

Cell Phone: _________________________

Email: ____

Date of Birth: ___________________

Primary Care Physician:___________________________ Phone:___________________

Address: ____

City / State: _______________________________________ Zip Code: ________________

Person responsible for payment: _________________________ Relationship: __________

Driver's License Number: _________________________________ State: ______________

Address: ____

City: ____ Zip Code: ________________

Phone: _________________________

Number in household: ________ Would others be willing to come in? **YES** ☐ **NO** ☐

Employer: ______________________________ Occupation: _________________________

Health Insurance Company: ____

Insurance Address: ____

Insurance phone number: ____________________ ID or Policy #: _____________________

Dr. Wendy Coughlin, Ph.D.
1101 S. Belcher Rd, Suite E – Largo, FL 33771 **Phone:** (727) 532-1997

ADULT INTAKE FORM

Have you been in therapy before? **YES** ☐ **NO** ☐

If yes, briefly provide details:____

____

____

Have you ever been hospitalized for mental disorders? **YES** ☐ **NO** ☐

If Yes, provide details:

____

____

____

Why are you seeking therapy at this time?: ____

____

____

What are your goals for therapy: ____

____

____

Describe your usual diet, including beverages:

- Breakfast:____
- Lunch:____
- Dinner:____
- Snacks:____

Do you drink caffeinated beverages? **YES** ☐ **NO** ☐

If yes, quantity: ____

Dr. Wendy Coughlin, Ph.D.
1101 S. Belcher Rd, Suite E – Largo, FL 33771 · **Phone:** (727) 532-1997

MEDICAL QUESTIONAIRRE

Name: ______________________________ **SS#:** _______________ **Date:** ________________

What medical problems, if any, are you currently having?

____

____

Are those problems being treated? **YES** ☐ **NO** ☐

By whom? ____________________________________

Last medical examination (date): __________________

Primary care doctor: ____________________________

Current psychotherapy medication (include dosage and schedule):

____

____

Prescribing Physician: __________________________________ **PCP** ☐ **Psychiatrist** ☐

What prescription or non-prescription drugs (including alcohol) are you currently taking or have taken in the last six months?

____

____

List past hospitalizations, operations, or serious illnesses:

- ____Year: _______________
- ____Year: _______________
- ____Year: _______________
- ____Year: _______________

Check any of the following diseases you have had:

Disease	At what age?	Disease	At what age?
☐ Thyroid Disorder	____________	☐ Diabetes	____________
☐ Chronic Bronchitis	____________	☐ Cancer	____________
☐ Emphysema	____________	☐ Heart Disease	____________
☐ Epilepsy (convulsion)	____________	☐ Stroke	____________
☐ Venereal Disease	____________	☐ Anemia	____________
☐ Asthma	____________	☐ Kidney Disease	____________
☐ Hay Fever	____________	☐ Liver Disease	____________
☐ Nervous Disorder	____________	☐ Hepatitis	____________
☐ Other	____________	☐ Other	____________

Do you use tobacco? **YES** ☐ **NO** ☐ What form? _______________________

WOMEN ONLY:

Are you pregnant? **YES** ☐ **NO** ☐

Perimenopausal? **YES** ☐ **NO** ☐

Dr. Wendy Coughlin, Ph.D.

1101 S. Belcher Rd, Suite E – Largo, FL 33771 ✆ **Phone:** (727) 532-1997

Menopausal? **YES** ☐ **NO** ☐

MEDICAL QUESTIONAIRRE

Family history with alcohol and/or drugs?

____

____

____

____

Do you drink alcoholic beverages? **YES** ☐ **NO** ☐

How often do you drink? **Daily** ☐ **3-5 times per week** ☐ **1-2 x per week** ☐ **Less** ☐

Do you sometimes drink more than you had planned? **YES** ☐ **NO** ☐

Have family of friends expressed concern about your drinking before? **YES** ☐ **NO** ☐

Have you ever been arrested for alcohol-related charges? **YES** ☐ **NO** ☐

Have you ever had an episode where you were unable to remember periods when you are drinking? **YES** ☐ **NO** ☐

Have you been treated for addictive illness before? **YES** ☐ **NO** ☐

If so, when? ____

Indicate which of the following you use (or have used):	**Within 1 year**	**Used in past**
Tranquilizers: Valium ☐ Xanax ☐ Ativan ☐ Klonopin ☐ Other ☐		
Pain Pills: Darvocet ☐ Oxycontin ☐ Hydrocodone ☐ Vicodin ☐ Percocet ☐ Morphine ☐ Heroin ☐ Methadone ☐ Other ☐		
Stimulants: Amphetamines ☐ "Speed" ☐ Dexedrine ☐ Adderall ☐ Caffeine ☐ Other ☐		
Sleeping Pills: Lunesta ☐ Restoril ☐ Ambien ☐ Other ☐		
"Street Drugs": Marijuana ☐ Crystal Meth ☐ "Shrooms" ☐ Cocaine ☐ Ecstasy ☐ Acid ☐ Crack cocaine Other		
Volatiles: Aerosols ☐ Glue Whippets Other ☐		
Others:		

Describe your usual sleep pattern:

Do you snore? **YES** ☐ **NO** ☐Page 2

Dr. Wendy Coughlin, Ph.D.
1101 S. Belcher Rd, Suite E – Largo, FL 33771 ✆ **Phone:** (727) 532-1997

WENDY E. COUGHLIN Ph.D., L.M.H.C.
Independent Psychotherapy Associates P.A.
1101 S. Belcher Rd. Suite E **Phone: (727) 532-1997**
Largo, FL 33771 **Fax: (727) 524-1332**

FEE SCHEDULE

Psychotherapy Fees
- 50 minute session…………………. $200.00
- 25 minute session…………………. $100.00
- Extended time……………………… $ 60.00 /15 min. interval
- Off-site……………………..………… $250.00 /hour (2 hour minimum)
- Phone consultation…………………. $ 60.00 /15 min. interval

Parenting Coordination Fees
- Retainer for first 5 sessions and Initial Case Management…………......... $1200.00
- Each session beyond first 5…….. $ 200.00

Legal Evaluations: Fees are based on complexity of evaluation.

Trauma Work
- Fees are based on clock hours…$240.00 /hour
- Pro-rated to 15 min. intervals

Late Cancellation (within 24 hours)……………… $ 100.00
No Show for Scheduled Appointment…………… $ 100.00
Treatment update (reports, letters, etc.)…….. $ 75.00
Returned Check Charge………………………………. $ 25.00
Copy of records (faxed, mailed, etc)…………… $ 1.00 per page

Dr. Coughlin does not participate in any insurance networks. Payments for sessions are due at the time of your scheduled appointment.

Wendy E. Coughlin, Ph.D., L.M.H.C.
Carol Walker, Office Manager

Please sign below to acknowledge receipt of this statement:

Signature________________________________Date___________________

WENDY E. COUGHLIN Ph.D., L.M.H.C.
Independent Psychotherapy Associates, P.A.
1101 S. Belcher Rd., Suite E **(727) 532-1997**
Largo, FL 33771 **Fax: (727) 524-1332**

PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Practice may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by ____________________________ Date: _______________
Patient Signature or Representative

Relationship to Patient (If other then patient): ___________________________________

Witness: _________________________________ Date: ___________________________