

 Child & Family Psychological Services, Inc.^{d/b/a}
Integrated Behavioral Associates

Intake Form (MAIL or FAX)

Today's Date: _____/_____/_____

Your Name: _____

Address: _____

E-mail: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

What clinician, if any are you hoping to see? _____

Preferred Clinician: No Preference Female Male

Name of person whom you are seeking services for? **(First Name, Middle Initial, Last Name)**

What is your relationship to this person? _____

Date of birth of potential client: _____/_____/_____

Potential client's gender: ___ Male ___ Female

Has this individual or any other immediate family members ever been seen at our practice?

YES NO

If yes, who? (Previous patient's name and clinician seen)

Marital Status (Parent's marital status if completing intake for child)

___ Single ___ Married ___ Separated ___ Divorced ___ Re-married ___ Widowed

Spouse/Parent's Name: _____

If marital status is other than married, please list other parent's:

Name: _____ Phone #: (_____) _____ - _____

Address: _____

If you are a parent seeking treatment or evaluation for a child and are divorced or separated from the child's other parent, please answer the following questions:

- Do you have sole legal custody? YES NO
(Legal custody is not the same as Physical Custody. Sole legal custody means the parent legally has complete control to make decisions for the child.)
- Do you believe the other parent will consent to treatment? YES NO
- Is there currently, or do you anticipate a legal battle over custody, visitation, or anything related to the child? YES NO

Who is the potential client's primary care physician?

Name: _____

Telephone #: (____) _____ - _____

Fax #: (____) _____ - _____

Address: _____

What practice is the primary care physician associated with:

- Granite Medical Center, Quincy
- South Shore Medical Center, Weymouth, Norwell, Kingston
- Other: _____

Who, if anybody, referred you to our practice? _____

Do we have permission to thank the person who referred you? YES NO

Do you plan on using your health insurance to pay for our services? YES NO

If so, what type of health insurance do you have? _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ / _____ / _____

Subscriber's Social Security Number *(required for United Health Plans)* _____

Insurance Identification Number: _____ Suffix # _____

Insurance telephone # for mental health benefits: (____) _____ - _____

Insurance telephone # for medical benefits: (____) _____ - _____

When does your health plan renew: _____ / _____ / _____ Unsure

Employer or other entity where health plan is obtained _____

Is the health plan a union or employer self-funded or trust plan? YES NO Unsure

If so, provide employer or plan contact name and telephone if available:

Name: _____

Phone #: (____) _____ - _____

Do you have secondary insurance? YES NO If yes, please complete:

What type of secondary health insurance do you have? _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's Social Security Number (required for United Health Plans) _____

Insurance Identification Number: _____ Suffix # _____

Insurance telephone # for mental health benefits: (_____) _____ - _____

When does your secondary health plan renew: ____/____/____ Unsure

Employer or other entity where health plan is obtained _____

Is the health plan a union or employer self-funded or trust plan? YES NO Unsure

If so, provide employer or plan contact name and telephone if available:

Name: _____

Phone #: (_____) _____ - _____

Has the potential patient used any mental health insurance benefits this calendar year? YES NO

If so, how many visits with a mental health clinician do you think you have used this year? _____

Has the potential patient ever been hospitalized for psychiatric reasons? YES NO

If yes, when was the last hospitalization: _____

Has the potential patient ever been hospitalized for substance abuse? YES NO

If yes, when: _____

Briefly describe the nature of the problem you are seeking services for:

Are the services you are seeking related to an automobile accident? YES NO

If related to an automobile accident please provide:

Insurance Carrier: _____

Address: _____

Insurance Adjuster Name (full name): _____

Policy Number: _____

Claim #: _____

Phone #: _____

Are the services you are seeking related to a workplace accident? YES NO

If related to a workplace accident, we do not accept workers compensation and services related to workplace injuries are NOT covered by your health insurance plan. Please check here if you accept and are will to pay our fees at time of service. I agree

Are the services you are seeking related to any type of lawsuit, hearing or other legal process? YES NO

If yes, please explain: _____

List all medical symptoms/problems the patient has:

List the names and professions of any other professionals you have consulted about these problems:

What type of services are you seeking? Please check all that apply.

- () Unsure. Would like evaluation and recommendations for services.
- () Medication
- () Individual Psychotherapy
- () Family Therapy
- () Group Therapy, which group? _____
- () Forensic Services
- () Neuropsychological Evaluation
- () Psychological Evaluation
- () Mediation
- () Consultation
- () Developmental Evaluation
- () Educational Therapy/Tutoring
- () Other, please specify: _____

If seeking medication, is the patient in *ACTIVE* psychotherapy? YES NO

If yes, how often seen on average?
___ weekly ___ every other week ___ monthly ___ less than monthly

Therapist Name: _____

Phone #: (_____) _____ - _____

If seeking medication, can the patient come between 10:00am-2:00pm on a monthly basis? YES NO

Which office are you requesting services for?

First Choice	Second Choice	Third Choice
<input type="checkbox"/> Norwood	<input type="checkbox"/> Norwood	<input type="checkbox"/> Norwood
<input type="checkbox"/> Holliston	<input type="checkbox"/> Holliston	<input type="checkbox"/> Holliston
<input type="checkbox"/> Weymouth	<input type="checkbox"/> Weymouth	<input type="checkbox"/> Weymouth
<input type="checkbox"/> Quincy**	<input type="checkbox"/> Quincy**	<input type="checkbox"/> Quincy**
<input type="checkbox"/> Abington	<input type="checkbox"/> Abington	<input type="checkbox"/> Abington

***For services in the Boston/Newton offices, please call (617) 259-1895. Do not submit this intake.

Do we have permission to leave a general message on your answering machine at the following:

Home		Work		Cell	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

When would you be able for services on a regular basis? Obtaining services for early morning or after 2:00pm on weekdays are extremely difficult given the high demand. Please be sure to check all that apply:

Anytime

Please note: at this time, most clinicians only have openings between 10:00am-1:00pm.

Mondays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm
Tuesdays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm
Wednesdays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm
Thursdays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm
Fridays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm
Saturdays			
<input type="checkbox"/> 8:00am-12:00pm	<input type="checkbox"/> 12:00pm-2:00pm	<input type="checkbox"/> 3:00pm-6:00pm	<input type="checkbox"/> after 6:00pm

Please allow 7-14 business days to complete the intake process.

**Please print out this form and fax it to us at 781-551-3396,
or mail it to:**

**Child & Family Psychological Services, Inc. / Integrated Behavioral Associates
89 Access Road, Suite 24 Norwood, MA 02062**