Blake Hamilton LCSW

blakehamiltontherapy.com
hamiltonlcsw@gmail.com **312-859-0694**

INTAKE FORM

Date _____ / _____ / _____

Name: _____ **SS#:** _____

Address: _____ **Date of Birth**: _____

_____ Sex: **M** **F** **NB**

Cell Phone: _____ Can I leave a message at this number? Yes No

Home Phone: _____ Can I leave a message at this number? Yes No

Work Phone: _____ Can I leave a message at this number? Yes No

Employer: _____ Years at Current Job: _____

Marital Status: **S M P D W Sep** If married, or with partner, name of partner: _____

Phone number of partner, if applicable: _____

Referral Source: _____

Can I mention your name when I thank the person who referred you? ____Yes ____No

Emergency Contact: _____
Name Relationship

_____
Address Phone #

Primary Care Physician: _____
Name **Phone** **Email**

Psychiatrist: _____
Name **Phone** **Email**

Financial Information: (Circle) Self-Pay Insurance Medicare Other_____

Please sign and date if you decided **not** to have your insurance or another third party payor pay for your fees:

Signature: _____ Date:_____

COMPLETE THE FOLLOWING SECTION **ONLY,** IF YOU ELECTED TO HAVE YOUR TREATMENT BE REIMBURSED BY YOUR INSURANCE COMPANY OR ANY OTHER THIRD PARTY PAYOR.

_____ _____
Insurance Company Name Phone # for Insurance Benefits

_____ _____
Insured's Name Primary Care Physician's Name

_____ _____
ID# Insured's Employer's Name

_____ _____
Group # Authorization # (If Applicable)

PLEASE NOTE: SHOULD YOU DECIDE TO HAVE YOUR INSURANCE COMPANY OR ANY OTHER THIRD PARTY PAYOR PAY IN FULL OR IN PART FOR YOUR TREATMENT, YOU WILL BE ASKED TO SIGN A RELEASE OF INFORMATION FORM, AUTHORIZING BLAKE HAMILTON, LCSW TO RELEASE TO YOUR INSURANCE OR TO ANOTHER THIRD PARTY PAYOR INFORMATION REGARDING YOUR DIAGNOSIS, PROGRESS NOTES, TREATMENT PLANS AND SUMMARIES.

SHOULD YOU DECIDE TO HAVE YOUR INSURANCE OR ANOTHER THIRD PARTY PAYOR PAY YOUR FEE IN PART OR IN FULL, YOU AGREE TO HOLD BLAKE HAMILTON LCSW HARMLESS FROM ANY LOSSES, DAMAGES, LIABILITIES, COSTS AND EXPENSES (INCLUDING WITHOUT LIMITATION, ATTORNEY'S FEES) ARISING FROM THE RELEASE OF SUCH INFORMATION.

PLEASE SIGN AND DATE IF YOU UNDERSTAND AND AGREE WITH THE ABOVE PROVISION:

Signature: _____ Date:_____

Reason for Seeking Services: _____

_____

Previous Mental Health Treatment:

Inpatient: Yes □ No □ **Outpatient**: Yes □ No □
When was last inpatient stay: _____ When was last outpatient service:
_____
Which Hospital? _____ Name of most recent provider: _____

Any other past treatment experiences? _____

Ever been on medications? Yes No If so, please list: _____

_____

Please list any current psychotropic medications: _____

If on current medications, name of provider: _____

Provider's Address _____ Phone #_____

Presenting Problem:

Current Symptoms:

Suicide Risk Assessment: Current ideation? Past ideation?

Past history of attempt? Details:

Homicide Risk Assessment: Current ideation? Past ideation?

Past history of attempt? Details:

Family History:

Past/Current Abuse or Neglect:

Alcohol/Substance Abuse:

Legal Issues:

Employment/Education:

Spirituality/Religion:

Medical Concerns: