Beyond Counseling, Inc.
11250 Roger Bacon Dr. Atrium #5
Reston, VA 20190
703-261-9201 (phone)
703-995-4642 (fax)

Patient Intake Forms

Therapy Preferences:

Interest in Telehealth/ Online / Video Counseling? ☐Yes ☐No

Parent/Guardian of children under 18years old
A legal guardian must be present at the intake assessment. All legal guardians must be aware of child's participation in therapy. ☐ I have read this disclosure and I am aware that by signing this form, I am attesting that all legal guardians have been informed and agree with the client's participation in therapy with Beyond Counseling, Inc. ☐ I have legal documentation stating that any other legal guardians do not have to be notified of the child's participation in therapy. (Please present this documentation at the Intake session).

Demographic Information:

Patient Name:	**Social Security #(if adult):**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Marital Status:	**Mobile Phone:**
Restrictions When Calling?:	**Texting OK?** ☐Y ☐ N
Email Address: Can we email you appointment reminders? ☐Y ☐N	**Emergency Contact Person:**
Primary Care Physician:	**Emergency Contact Phone:**
Psychiatrist (if any):	**How did you hear about us?**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

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Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Self-Pay? ☐ Yes ☐ No

Insurance Information

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

Please be aware that in the case of divorced/separated parents, it is the responsibility of the scheduling parent to pay any patient balance due on a child's account. If there is a custodial financial agreement between parents, it will be the scheduling parent's responsibility to collect any money due.

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PATIENT HISTORY FORM

Briefly describe why you are seeking treatment:

When did the problems first begin?

Previous mental health counseling or Inpatient stays? (If yes, please list with year attended)

Please check the box next to any items below that you are currently experiencing or have experienced in the past. Feel free to add any others next to "Other Concerns or Issues".

☐ Abortion	☐ Financial Troubles	☐ Nightmares
☐Abuse- emotional, mental, sexual	☐ Friendship Problems	☐Obsessions, Compulsions
☐ Aggression	☐ Gender Identity	☐Panic or Anxiety Attacks
☐ Alcohol Use	☐ Grieving, Mourning	☐ Parenting
☐ Anger	☐ Guilt	☐ Poor Self-Care
☐ Ambition	☐ Headaches, Pains	☐ Relationship Issues
☐ Anxiety	☐ Hearing Voices	☐ Sadness
☐ Attention Problems	☐ Hyperactivity	☐ Self-Harm
☐ Childhood Issues	☐ Impulsiveness	☐ Self-Control
☐ Communication	☐Interpersonal Conflicts	☐ Self-Esteem
☐ Crying	☐ Legal Matters	☐ Sexual Conflicts
☐ Depression	☐ Loneliness	☐ Shyness
☐ Distractibility	☐ Loss of Control	☐ Sleep Problems
☐ Domestic Violence	☐Loss of Interest in Activities	☐ Spirituality
☐ Drug Abuse	☐Loss of Interest or Addiction to Sex	☐ Stress-managment
☐ Education	☐ Low Mood	☐ Suicidal Thoughts
☐ Employment Issues	☐ Medical Concerns	☐ Thought-Distortion
☐ Fatigue, Low Energy	☐ Memory Problems	☐Threats of Violence to others
☐ Fears, Phobia	☐ Mood Swings	☐ Weight and Diet Issues

☐Helplessness/Hopelessnes	☐ Nervousness	☐ Withdrawal- Isolation
☐Other Issues or Concerns? Please List:		

FAMILY HISTORY

Please list the names and ages of those in your immediate family.

NAME	AGE	RELATIONSHIP	If Deceased, age and cause of death

FAMILY MENTAL HEALTH HISTORY

Immediate and extended family

Condition	List Family Member
☐Alcohol/Substance Abuse	
☐Anxiety	
☐Depression	
☐Domestic Violence	
☐Sexual Abuse	
☐Eating Disorder	
☐Obesity	
☐Obsessive Compulsive Disorder	
☐Schizophrenia	
☐Suicide Attempts	
☐Other diagnosed mental health condition? Which ones?	

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MEDICATIONS/SUPPLEMENTS

Name	Dosage	Condition	Date Began/Stopped

SUBSTANCE USE

☐ N/A (Client under 12yrs old)

Substance	Duration	Frequency	Last Use
☐Caffeine			
☐Tobacco			
☐Alcohol			
☐Marijuana			
☐Opiods/Narcotics			
☐Amphetamines			
☐Cocaine			
☐Hallucinogens			
☐Others? Please list.			

PATIENT AUTHORIZATION

I certify that all information provided is accurate. I authorize the provider to bill my insurance and receive reimbursement for services rendered. The provider is authorized to release necessary information to the billing staff and my insurance carrier to receive payment for services rendered. I understand that I am responsible for all charges not covered by my insurance. Furthermore, should legal action or collection services become necessary to collect my unpaid balance, I agree to pay all legal and/or collection fees.

Patient Signature/Guardian ____ **Date**_____________________

Patient /Guardian Printed Name ____