Roberta Rothstein LICSW
1250 Connecticut Avenue NW 7th Floor
Washington, DC 20036 202.517.7252

Client Intake Form

Date_____

NAME_____DOB / / Soc Sec #_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE: H_____W_____CELL_____

EMAIL (please print):_____

HEALTH INS CARRIER: _____ID#_____GROUP#_____

EMPLOYER_____ADDRESS_____

How did you hear about my practice? My website_____Psychology Today online_____ Friend_____Health Care Professional (Name)_____Web search_____Other (specify)_____

EMERGENCY CONTACT: _____RELATIONSHIP_____PHONE_____

Why have you decided to come to therapy at this time?_____

_____

What do you see as the main problem (s) in your life now?_____

_____

How have this/these problem(s) affected your: (Please be as specific as possible. This helps me help you.)

Work life_____

Home life_____

Relationships_____

Physical and mental health_____

Beliefs about yourself and others_____

How long has this been a problem for you?_____

Do you currently have a medical condition or problem? ____yes____no. If yes, please describe_____

_____

Are you being treated for this condition? ____yes____no. If yes, please list your treatment professional(s):

_____

Are you currently taking prescription medication, vitamins or herbal supplements? ____yes ____no. If yes, please list all:

How often?_____

Roberta Rothstein LICSW Client Intake Page 2 NAME_____

In the last year have you experienced (check all that apply):

_____A serious physical illness
_____Death of a loved one
_____Layoff from a job
_____Work promotion or change of responsibilities
_____Other major job change
_____Financial difficulty
_____Birth or adoption of a child
_____Marriage _____Separation or divorce
_____Overnight stay at a hospital
_____Serious illness of a child, parent, close relative or friend
_____Move to another city
_____Educational goal (graduation, finish a program)
_____Marked changes in mood or ability to function
_____Change in patterns of eating or alcohol consumption

Have you been in treatment previously with a mental health professional or at a mental health facility? ____yes ____no
If yes, briefly describe including dates, duration of treatment and reason treatment ended:

_____

_____

It is often useful and important to discuss your case with the health care professional who referred you to my practice, where appropriate. As well I may need to discuss your case with another health care professional for purposes of referring you for adjunct treatment or for assuring you the best treatment. This is only possible with your written permission. Please sign the following statement if you choose to give me that permission. Please understand that, in order to give you the best treatment possible, it is sometimes necessary for me to contact relevant health care professionals.

I hereby give Roberta Rothstein, LICSW, MSW, permission to discuss my care and treatment with:

_____
Or other relevant health care professional for purposes of aiding in my treatment.

Signature_____Date_____

Payment is expected at the time of service. I am a Preferred Provider with Blue Cross/Blue Shield Carefirst Network and that carrier only. Copay situations apply only to clients under BC/BS plans. My professional services are insurance reimbursable for all other plans that cover behavioral health as out of network coverage. It is the client's responsibility to check with his/her health insurance provider before the first appointment to clarify individual coverage.

My professional services are confidential to the fullest extent of the law. However I cannot control the handling of client data by the client's insurance company. Wherever possible, I provide only the minimum client information required by the insurance company.

Your appointment has been reserved just for you. Please honor it by giving at least 24 hours notice (via text, Email or phone call) for all cancellations. <u>You will be charged in full for appointments cancelled with less than 24 hours notice (BC/BS clients as well. See below).</u> (It may sometimes be possible that I can offer you another timeslot that week, but that is not guaranteed.)

For BC/BS clients, you are charged <u>the full amount BC/BS reimburses mental health providers for this service</u> (not just the copay) for all sessions cancelled within 24 hours. Please refer to separate BS/BS form for details.

I have read, understand and agree to abide by the 24 hour notification rule as listed above.

Signature_____