

PSYCHOTHERAPY INTAKE FORM
Nancy Siskowic, NP, NCMP, CNS-BC

Psych/Mental Health Nurse Practitioner CNS - Board Certified

Nurse Practitioner Women's Health
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Date: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Work Phone: _____ **Fax:** _____

Date of Birth: _____ **Age:** _____

Referred by: _____

Emergency Contact: _____ **Phone:** _____

Primary Health Care Provider: _____

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**Office Use only: CPT:** \_\_\_\_\_ **DX:** \_\_\_\_\_

The following information can be answered as fully or briefly as you wish.

*What is the reason for your visit?*

*What questions or concerns would you like addressed during your first visit?*

*Please list any major illnesses, injuries, surgeries or hospitalizations*

Does your medical history include any of the following (please underline all that apply)

|                             |                        |
|-----------------------------|------------------------|
| Migraines                   | Colitis                |
| High Blood Pressure         | Diarrhea               |
| Stroke                      | Constipation           |
| High Cholesterol            | Bloody or Black Stools |
| Heart Attack                | Hepatitis              |
| Easy Bruising               | Liver Disease          |
| Blood Clots                 | Gall Bladder Disease   |
| Anemia                      | Breast Biopsies        |
| Indigestion                 | Endometriosis          |
| Frequent Nausea or Vomiting | Fibroids               |
| Diabetes                    | Teeth or Gum Problems  |
| Thyroid                     | Frequent Falling       |
| Asthma                      | Losing Height          |
| Arthritis                   | Broken Bones           |
| Back pain                   | Weight                 |
| Seizures                    | Cancer                 |
| Macular Degeneration        | Infertility            |
| Cataracts                   | Suicidal Thoughts      |

Other...\_\_\_\_\_

Date of last Chemistry Panel: (blood work?)\_\_\_\_\_ Colonoscopy:\_\_\_\_\_

**Family History:**

**Please list family member(s) who have the following...**

**High blood pressure**

**Heart attack**

**Stroke**

**Blood clots**

**Glaucoma**

**Diabetes**

**Osteoporosis**

**Hip fracture**

**Breast cancer**

**Ovarian cancer**

**Colorectal cancer**

**Alzheimer's / Dementia**

**Depression**

**Alcoholism**

**Prostrate cancer**

**Drug addiction**

**Is there anything about your family's health history that you would like to discuss?**

**Please list all medications and supplements (over the counter) you are currently taking...**

**NAME**

**DOSE**

**FREQUENCY**

**HOW LONG**

**Are you allergic to any medications? \_\_\_\_\_ If yes please list which ones and your reaction...**

**Do you have any other allergies? \_\_\_\_\_ If yes please indicate to what, and your reaction...**

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_

What do you do? \_\_\_\_\_

Do you consider your diet excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

Please explain...

Do you smoke cigarettes? \_\_\_\_\_ How many per day \_\_\_\_\_ Do you want to quit \_\_\_\_\_ Please explain...

Do you drink alcohol? \_\_\_\_\_ How many drinks each week? \_\_\_\_\_  
Each day? \_\_\_\_\_

Do you feel a need to cut down on you drinking? Please explain...

\_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ Please explain \_\_\_\_\_

\_\_\_\_\_

Within the last year have you experienced emotional, physical or sexual abuse? \_\_\_\_\_

What are your current major stressors or life changes?

\_\_\_\_\_

Any major changes in family health in the past year \_\_\_\_\_

\_\_\_\_\_

How do you handle stress?

\_\_\_\_\_

What do you do to relax?

\_\_\_\_\_

## **Limits of Confidentiality Statement**

**Nancy Siskowic, NP, CNS-BC**

**36 Malaga Cove Plaza #203  
Palos Verdes Estates, CA, 90274**

Whatever we talk about, I will hold in strictest confidence. There are some legal exceptions to this:

- If you authorize a release of information with a signature.
- If your mental condition becomes an issue in a law suit.
- If you present as a physical danger to yourself (Johnson v county of Los Angeles, 1983)
- If you present as a danger to others (Tarasoff v Regents of University of California, 1967)
- If child or elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes)

In the latter two cases, I am required by law to inform potential victims, protective agencies, and/or legal authorities so that protective measures may be taken.

### **Payment for Services**

Payments are due and payable at each appointment. If you plan to utilize your insurance benefits, you are responsible for obtaining prior authorization for treatment. **SUPER BILLS WILL BE PROVIDED AT THE END OF EACH MONTH FOR SUBMISSION TO YOUR HEALTH INSURANCE COMPANIES.**

### **Cancellation & Missed Appointment Policy**

Scheduled appointment times are reserved especially for you. If you miss or cancel an appointment with less than 24 hours notice, you will be responsible for the fee. Your insurance will not be billed for fees associated with missed or cancelled appointments.

### **Prescriptions and Refills**

Refills can be handled by fax. Please allow 3 days for all refill requests. When you have a week remaining on your prescription, contact your pharmacy and request a refill. If you are not current with your appointments, refill requests may be denied.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_