1638 R St. NW, Suite 311
Washington, DC 20009
p. 202-746-5838 f. 202-331-3759

____
Date of Intake

First Name	**Middle Name**	**Last Name**

Gender	**Date of Birth**

Home Address	**City**	**State**	**Zip Code**

Phone	**Email**

Circle Preferred Method of Contact: **Text** **Call** **Email**

Primary Insurance Provider	**Member ID**	**Group ID**

Secondary Insurance Provider	**Member ID**	**Group ID**

Emergency Contact	**Number**	**Relationship**

HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical concerns? ____

____

____

Has you ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, hearing or vision problems, headaches, tuberculosis, meningitis, seizures, heart disease/ stroke, diabetes, asthma, allergies, cancer, surgeries, incontinence, gastrointestinal issues, and/ or any other conditions:

____

____

____

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many sessions did you have? Was the experience helpful or not? How so?

____

____

____

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

____

____

____

Please list your current prescription medications with dosage (psychiatric and general health):

____

____

____

Please list any previous psychiatric medications (with dosage and dates): ______________________

____

Who is your primary care physician? ____

Who is your psychiatrist (if applicable)? ____

When was your child's last complete physical exam (mo/year)? ______________________

How much are <u>each</u> of the following areas currently a problem for you?

	Not at all 1	A little 2	Somewhat 3	Considerably 4	Terribly 5
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Intimate Partner Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School/ Work Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Have you experienced any stressors (recent or during the past year) that may be contributing to these difficulties (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?

Please Circle **Yes** **No**

If yes, please describe:____

____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand you:

____

____

INFORMED CONSENT

We are committed to actively involving you in the therapeutic process. You have the right to receive adequate information to enable you to make decisions regarding your treatment.

Conducting Psychotherapy with you requires your Informed Consent. Before giving consent for psychotherapy services, it is important that you are informed of the potential benefits and risks of psychotherapy treatment. You are encouraged to discuss the potential benefits and risks with your therapist, as well as, ask questions about treatment options, rights and responsibilities. You are encouraged to discuss any fears, concerns or doubts you may have.

Potential Benefits. While no one can guarantee or promise specific outcomes, there are a number of positive benefits that can result from psychotherapy services. The benefit of psychotherapy services usually depends on several factors such as the specific issue(s) or difficulties you are experiencing, the goals you have set for therapy and the degree of follow through with treatment. Below is a list of some common benefits of psychotherapy. This is not an exhaustive list.

- Improvement in your general mood and anxiety level.
- Increased self-awareness, self-esteem, and confidence.
- Increased ability to set and achieve goals.
- Increased ability to manage life stressors.
- Increased ability to manage strong emotional reactions such as nervousness, anger, fear or sadness.
- Increased ability to trust, feel close to and communicate your feelings, thoughts and needs more effectively.
- Increased ability to stop behaviors that are harmful and engage in healthier behaviors.
- Improved ability to manage and cope with symptoms and triggers.

Potential Risks. In general, there are few risks to psychotherapy services. However, as with any health care service, there is the possibility of some potential risk. Below is a list of some common risks associated with psychotherapy services. This is not an exhaustive list.

- You may not experience any improvement in mood, anxiety levels, or achievement in goals.
- You may experience worsening of symptoms or intensity of feelings, especially in the beginning of therapy.
- Important people in your life may not support your decision to be in therapy or the changes you make.
- If you apply for a job that requires a security clearance, an in depth back ground check may be conducted and your mental health records may be used in that decision making process.
- You may experience some discomfort to include remembering and discussing unpleasant experiences or events.
- You may experience some dissatisfaction when your therapists challenges your perceptions or perspective.
- Your insurance company may exclude your diagnosis as a covered service and you would be responsible for full payment of services provided.

By signing this Informed Consent form I agree with the following statements:

• I have been provided with enough information so that I can make an informed decision on the proposed therapy.
• I have been provided with information regarding the nature of my condition/diagnosis.
• I have had an opportunity to ask questions and receive additional information that I have requested.
• I understand that it is not possible to predict or guarantee the results of this therapy.
• I understand that psychotherapy is voluntary and that I may cease treatment at any time.
• I agree that I must give 24 hours advanced notice any time I am unable to attend my scheduled appointment and that without 24 hours advanced notice, I will be held responsible for payment of the full fee of the missed session.
• I understand that I am ultimately financially responsible for payment of services provided.
• I authorize billing of my insurance plan if Aya Behavioral Health, LLC is a contracted provider with my insurance plan.

I, ____ (print name) consent to this treatment/procedure/ therapy. By signing below, I acknowledge that I have read or had explained to me and understand the above and any additional information indicated. I have had a chance to ask my provider any questions. I voluntarily consent to treatment. This consent lasts for as long as the treatment continues. I understand that I may withdraw this consent at any time.

____ _______________
Signature Date

Provider Confirmation: I informed the consenting party of the condition requiring treatment, and have, consistent with my clinical judgment, explained the nature, purposes, risks, benefits of therapy. I have answered any questions to the best of my ability, and the client has consented to the procedure or treatment indicated above.

____ _____________
Signature Date