
Adult Intake Form


Patient's Name: _____

## PLEASE READ AND INITIAL EACH STATEMENT

_____**CONSENT TO TREATMENT**: I consent to mental health (i.e. psychological/ psychiatric) evaluation and/or treatment by staff from Katie's Way. In doing so, I understand, acknowledge and affirm that such mental health (i.e. psychological/ psychiatric) evaluation and/or treatment services may involve physical evaluation and blood testing.

____**ACKNOWLEDGEMENT:** By initialing here, I acknowledge that all information provided, whether verbal, in writing, or through any form of digital communication will be utilized and binding to Katie's Way, LLC or Katie's Way Charities, Inc., or collectively. Further, at any point in which Katie's Way is referenced, whether verbally, in writing, or through any form of digital communication this will have the same meaning as Katie's Way, LLC or Katie's Way Charities, Inc., or collectively.

_____**RECEIPT OF PRIVACY PRACTICES**: We are required by law to provide this notice to you and obtain your acknowledgement of this receipt prior to providing any services to you. I acknowledge receipt of Notice of Privacy Practices.

_____**EMERGENCY RESCHEDULES:** It will be a top priority for Katie's Way staff to see you on time for your appointments. However, due to unexpected clinical emergencies, there may be a time that clinical staff at Katie's Way need to call and delay a clinic appointment or reschedule it for another day.

_____**LATE ARRIVALS:** We ask that you call and let the front office know if you are running late to your appointment. If you are more than 10 minutes late for a medication appointment, or more than 15 minutes late to a therapy appointment, you will need to reschedule.

_____**MEDICATION REFILLS:** If you need a refill, please call your pharmacy first. Please allow 72 hours for a prescription to be refilled. If you have not had an appointment within the recent months you may be required to schedule an appointment to be seen before we refill your medication. Requests will not be received by the Katie's Way medical staff on weekends or holidays. Refills may be delayed if you do not schedule and attend regular appointments.

_____ _____

Patient Signature Date

Patient's Name: _____

**SCHEDULING & ATTENDANCE POLICY**

**How appointments are scheduled:**

Your treatment plan will be determined by the individual provider at the initial evaluation and on an ongoing basis. Your provider will recommend the number of treatment visits and visit frequency.

Our scheduling policy is that appointments are typically scheduled out 2-months at a time. After you discuss your treatment plan with your provider at each visit, please stop at the front desk to schedule and confirm upcoming appointments. You can always add additional appointments to the schedule 2-months ahead of time to plan and hopefully get the appointment that work best for your schedule. Please understand that certain times of the day are the most popular for all patients or families. Our providers and scheduling staff attempt to accommodate all our patients' needs to the best of our abilities. However, there may be some situations in which appointments times are only available at certain times of the day.

**The importance of appointment attendance:**

We realize that appointments may need to be rescheduled from time to time due to conflicts of schedule, family matters, and illnesses.

Not showing for scheduled appointments or cancelling an appointment without sufficient notice is a significant issue for 3 main reasons:

1. Not keeping an appointment (No-shows) or having late cancellations of your scheduled appointments negatively impacts you or your child's treatment. Psychological and psychiatric treatments require ongoing consistency for them to be effective. If you miss scheduled appointments it can delay the treatment plan or make the treatment less effective, making it harder for us to help you or your child the best that we can.

2. No-shows and late cancellations can negatively impact others in the community. If there is a no-show or a late cancellation, it does not allow us to fill that appointment time with other patients that may need to get in or are waiting for a sooner appointment. Further, no-shows and cancellations is one of the biggest challenges Katie's Way faces in being able to provide services to our community.

3. No-shows and late cancellations affect our providers; their time is valuable and when you cancel or no-show for an appointment they now have space in their schedule that was reserved for you personally.

**Our Attendance Policy:**

If you become aware that you will miss an appointment or need to reschedule, please call the office at 785-320-7331 as soon as you can.

1. We ask that you call and let the front office know if you are running late to your appointment. If you are more than 10 minutes late for a medication appointment, or more than 15 minutes late to a therapy appointment, it is at each provider's discretion on whether you can be seen that day. If you are seen it will only be during the remaining allotted time of your appointment.

2. For cancellations, our policy is that you let us know **by 3:00PM the day prior** to your scheduled appointment that you need to cancel. If your appointment is on a Monday, please make every effort to

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**SCHEDULING & ATTENDANCE POLICY CONTINUED**

inform us of a cancellation by 3:00PM the Friday prior to your appointment. If this is not possible, please call and leave a voicemail to let us know over the weekend.

3. If you need to cancel an appointment late (after 3:00PM the prior business day) please call and let us know the reason for cancelling. By calling and letting us know, even if it is late, will allow us to try to fill that open spot with a patient on our wait list. Reasons for late cancellations will be reviewed by your provider and the Katie's Way director so that a reasonable plan for your treatment can be continued.

4. The **first no-show or late cancellation** will result in a reminder of our attendance policy and encouraging you to give us appropriate notice if you cannot keep any upcoming appointments.

5. The **second no-show or late cancellation within a 2-month period** may result in the following:

* Your future scheduled appointments being cancelled.

* You may need to schedule 1 visit at a time with your provider rather than scheduling out appointments.

* If you successfully attend 3 scheduled appointments in a row without no-shows or late cancellations, you would then be allowed to schedule out for 2-months again and resume the regular scheduling policy.

6. If no-shows or late cancellations continue to occur, your appointment attendance will be addressed by your individual provider and the Director of the clinic. Katie's Way reserves the right to discharge you or your child from our care due to frequent cancellations or no-shows.

*Important: Katie's Way reserves the right to discharge any patient from services/care*

***By signing below, you acknowledge that you have read and understand the scheduling and attendance policy.***

_____
Patient Printed Name

_____ _____
Patient Signature Date

# Adult Intake Form

Patient's Name: _____

## PATIENT INFORMATION

Patient Legal Name _____
First Middle Last

Patient Preferred Name _____

Patient Date of Birth _____ Gender _____

Billing Address _____
Street City State Zip Code

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

## INSURANCE INFORMATION

Primary Insurance Provider _____Effective Date _____

Policy Number _____ Group Number _____

Name of Subscriber _____
First Middle Last

Subscriber Date of Birth _____ Relationship to Patient _____

Subscriber Gender _____ Subscriber Social Security No. (Tricare only) _____

Subscriber Address _____
Street City State Zip Code

## PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____

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**INSTRUCTIONS:** Complete and return this form along with the following:

- ✓ A copy of your insurance card(s), if applicable
- ✓ Copies of any 504 plans or other educational testing records, if applicable
- ✓ A copy of your picture ID.

Date of Birth: _____/_____/_____

Who referred you to our clinic? _____

Who is your primary care doctor? _____

Reason for referral: _____

What is your main concern? _____

_____

How can Katie's Way help you the most?_____

_____

Have you been seen by other developmental or mental health professionals, such as psychologists, psychiatrists, or counselors?

□ No □ Yes, list and explain.

| Name of Professional | Date(s) | Reason/Diagnosis |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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**CURRENT LIVING SITUATION/FAMILY BACKGROUND:**

Are there other individuals in your place of residence? ☐ No ☐ Yes, please list:

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

Birth Mother: _____ Age: _____

Occupation: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Alternate Phone: (____)____-_____

Address: _____
Street City State Zip

Birth Father: _____ Age: _____

Occupation: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Alternate Phone: (____)____-_____

Address: _____
Street City State Zip

If you do not live with- or were not raised by your birth parents, other adults that were caregivers? (Otherwise, leave blank)

Name: _____ ☐ Stepmother ☐ Adoptive Mother ☐ Guardian ☐ Foster Mother

Age: _____ Occupation: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Alternate Phone: (____)____-_____

Address: _____
Street City State Zip

Name: _____ ☐ Stepfather ☐ Adoptive Father ☐ Guardian ☐ Foster Father

Age: _____ Occupation: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Alternate Phone: (____)____-_____

Address: _____
Street City State Zip

Brothers and Sisters

| Name | Sex | Age | Living with you? | Health or Learning Problems |
|---|---|---|---|---|
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |

Adult Intake Form

Patient's Name: _____

**MEDICAL HISTORY**

Do you have allergies to any medications? _____

_____

**MEDICATIONS**

| Current Medications (List names and what for) | | | | |
|---|---|---|---|---|
| Name of Medications | 1. | 2. | 3. | 4. |
| Dose/Frequency | | | | |
| Start Date | | | | |
| Reason for Use | | | | |
| Prescriber | | | | |

| Previous Medications (List names and what for) | | | | |
|---|---|---|---|---|
| Name of Medications | 1. | 2. | 3. | 4. |
| Dose/Frequency | | | | |
| Start Date | | | | |
| Reason for Discontinuing | | | | |
| Prescriber | | | | |

| Dietary/Herbal Supplements (List names and what for) | | | | |
|---|---|---|---|---|
| Name of Medications | 1. | 2. | 3. | 4. |
| Dose/Frequency | | | | |
| Start Date | | | | |
| Reason for Use | | | | |

Serious Illnesses, Injuries, Surgeries, or Hospitalizations (including psychiatric hospitalizations):

Date or Age Reason (Type of Illness/Injury/Surgery/Hospitalization)

_____

_____

_____

_____

_____

Handedness: ☐Right ☐ Left ☐ Both

Have you had occupational or physical therapy? ☐No ☐ Yes, explain: _____

_____

_____

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Have you had speech/language therapy? ☐No ☐ Yes, describe: _____
_____

Do you regularly see a primary care physician? If so, who is your provider and approximately when was your last visit? _____

Do you regularly use alcohol or recreational drugs? _____

**CURRENT HEALTH FUNCTIONING:**

**SLEEP**
What is your typical bedtime? _____ How about typical wake time?_____

Do you have any concerns with your sleep? _____
_____
_____
_____

**DIET/NUTRITION**
Do you have any concerns about your diet, eating behavior, or recent changes in appetite/weight? _____
_____
_____
_____

**PHYSICAL ACTIVITY**
Do you get any physical activity or exercise on a daily basis? If so, what kinds of activities?
_____
_____
_____

**SOCIAL FUNCTIONING/SOCIAL SUPPORT:**

Do you have any concerns about your functioning or relationships?
_____
_____
_____

What do you like to do for fun, or any hobbies? _____
_____
_____

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Who would you consider is a source of social support? _____

_____

**EDUCATIONAL/WORK:**

Do you attend any school/college currently?_____

If you are no longer in high school, where did you attend? _____
Did you graduate? _____

Any Educational Diagnosis current/past: ☐ Learning Disability ☐ Behavior Disorder ☐ Intellectual Disability

Any academic problems at school current/past? _____

_____

Any behavioral problems at school current/past? _____

_____

Do you currently work part-time or full-time? If so, where and what kind of hours? _____

_____

_____

**SUMMARY:**

Anything else that you think is important for us to know about you? _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Patient or Patient's Personal Representative

Printed Name of Patient/ Person Completing This Form

_____/_____/_____

Date