INTAKE DATA

Date: / /	Therapist:		
Name:	Preferred Name:	Phone: ( ) -	
Address: *(Including for emergencies)*	City:	State:	Zip code:
Billing Address: *(If different from primary address)*	City:	State:	Zip code:
Birthdate: / /	Age:		
Relationship Status: ☐Single ☐Separated ☐Domestic Partner ☐Married ☐Divorced			
Employer / School:			
Emergency Contact Name:	Phone: ( ) -	Relationship:	

Current or past significant medical problems, allergies:
Current medications:
Primary Care Physician:

Parent / Guardian information **if client is a minor**		
Parent/Guardian Name #1:		
Birthdate: / /	Age:	Cell phone: ( ) -
Employer:	Work phone: ( ) -	
Parent/Guardian Name #2:		
Birthdate: / /	Age:	Cell phone: ( ) -
Employer:	Work phone: ( ) -	
Name of Spouse or Domestic Partner:		
Birthdate: / /	Age:	Cell phone: ( ) -
Employer:	Work phone: ( ) -	
Names and birthdates of other adults in the home (if applicable):		

Children or others in the home (if applicable)		
Name:	Birthdate: / /	Age:
Name:	Birthdate: / /	Age:
Name:	Birthdate: / /	Age:
Name:	Birthdate: / /	Age:
Name:	Birthdate: / /	Age:

Referred by:
Reason for referral:

NAA PERMISSION TO CONTACT CLIENT

NAA wants to be sure that they can keep in communication with you during your involvement with NAA. This may involve making and changing appointments, billing, closing due to inclement weather and/or other business and treatment activities. NAA also wants to ensure your privacy and protect your confidentiality. Please list below **only** those numbers and locations where you wish to be contacted, keeping in mind there are security/privacy risks to all these forms of communication. NAA uses standard business measures to protect the security/privacy of your communication, but cannot guarantee that unauthorized access could never occur. You have a right to withdraw your permission regarding these means of communication in writing at any time.

Self or **Parent/Guardian #1** (if client is a **minor**)			
Name:			
Mailing address:	City:	State:	Zip code:
Home phone: ( ) -	Cell phone: ( ) -		Fax: ( ) -
Self or **Parent/Guardian #2** (if client is a **minor**)			
Name:			
Mailing address:	City:	State:	Zip code:
Home phone: ( ) -	Cell phone: ( ) -		Fax: ( ) -

E-mail Communication Informed Consent

E-mail communication between NAA therapists and clients presents some unique ethical and legal issues. Each NAA therapist decides if they want to use e-mail communication so please discuss this with your therapist. Below is the NAA policy on e-mail communication:

E-mail is only used for scheduling purposes or to provide clinicians with updated demographic information, NAA therapists may e-mail mental health educational information or homework assignments to clients. All other communication should occur in person. E-mail is not to be used for communication of urgent or emergency situations. Clients should call 911 or go to their local emergency room in an emergency situation. E-mails will be reviewed during usual business hours. E-mails will be printed and placed in the client's medical record. E-mail is not best for communicating emotional issues, sensitive concerns or items that need to be processed and explored. E-mail communication from the client must include their name and contact information. NAA does not guarantee a specific "turn-around" time to respond to e-mail communication. NAA cannot guarantee the security of e-mail communication and does not guarantee against the loss in transmission of e-mail communication. Clients are forewarned that e-mail communication has security limitations beyond the control of NAA. NAA staff will charge a fee for reading e-mail communication that is longer than a brief appointment time message. This fee is not covered by insurance. NAA staff reserve the right to not read lengthy e-mail and to bring any e-mail communication to the next client session to be processed.

E-mail address: _____

I give permission for NAA therapist to use this email address to communicate with me ☐

I **do not** give permission for NAA therapist to use this email address to communicate with me ☐

Client signature: _____ Date: _____

Parent/Guardian/Personal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____