

Catherine Ellis, M.A.  
 Limited Licensed Psychologist  
 2001 Hudson Avenue  
 Kalamazoo, MI 49008  
 269-341-9725

Date \_\_\_\_\_

Dx \_\_\_\_\_

**INTAKE FORM**

**PERSONAL INFORMATION**

Client \_\_\_\_\_ Responsible Party (if different) \_\_\_\_\_

Address \_\_\_\_\_ Address (if different) \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_ \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Cell \_\_\_\_\_ May I contact you by phone? \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Policy Holder \_\_\_\_\_ Policy Holder \_\_\_\_\_

Address (if different) \_\_\_\_\_ Address (if different) \_\_\_\_\_

\_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Member # \_\_\_\_\_ Policy Holder's Member # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Employer's Address \_\_\_\_\_

\_\_\_\_\_

**FAMILY INFORMATION**

| NAMES                            | M/F | AGE | BIRTH DATE | EDUCATION | OCCUPATION |
|----------------------------------|-----|-----|------------|-----------|------------|
| Client:                          |     |     |            |           |            |
| Spouse/Partner:                  |     |     |            |           |            |
| Children/Step-Children/Siblings: |     |     |            |           |            |
| 1.                               |     |     |            |           |            |
| 2.                               |     |     |            |           |            |
| 3.                               |     |     |            |           |            |
|                                  |     |     |            |           |            |

**MEDICAL INFORMATION**

Physician \_\_\_\_\_

Describe any health problems you have. \_\_\_\_\_

What medications do you take? \_\_\_\_\_

What serious illnesses have you had? \_\_\_\_\_

List any prior surgeries. \_\_\_\_\_

Have you had prior counseling or therapy? \_\_\_\_\_ When? \_\_\_\_\_

What was the concern? \_\_\_\_\_

Who was your counselor? \_\_\_\_\_

Have you ever been hospitalized for psychiatric treatment? No \_\_\_\_\_ Yes \_\_\_\_\_ When? \_\_\_\_\_

Where were you hospitalized? \_\_\_\_\_ For how long? \_\_\_\_\_

What brings you to counseling now? \_\_\_\_\_

How long have your current problems existed? \_\_\_\_\_

Describe your present concerns: (Circle one) Mild Moderate Moderately Severe Severe A Crisis

Where did you get my name? \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_  
(Name) (Relationship) (Phone)

**PLEASE MARK ALL THAT APPLY:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> crying spells           | <input type="checkbox"/> fast heartbeat       | <input type="checkbox"/> money problems            |
| <input type="checkbox"/> unable to have fun      | <input type="checkbox"/> always worried       | <input type="checkbox"/> relationship concerns     |
| <input type="checkbox"/> feelings easily hurt    | <input type="checkbox"/> frequent sweating    | <input type="checkbox"/> work difficulties         |
| <input type="checkbox"/> lacking in confidence   | <input type="checkbox"/> dizziness            | <input type="checkbox"/> sexual problems           |
| <input type="checkbox"/> constipation            | <input type="checkbox"/> shaky hands          | <input type="checkbox"/> can't hold a job          |
| <input type="checkbox"/> feeling grouchy         | <input type="checkbox"/> stomach trouble      | <input type="checkbox"/> excessive drinking        |
| <input type="checkbox"/> always tired            | <input type="checkbox"/> nightmares           | <input type="checkbox"/> excessive medication use  |
| <input type="checkbox"/> poor appetite           | <input type="checkbox"/> feeling tense        | <input type="checkbox"/> excessive drug use        |
| <input type="checkbox"/> depressed               | <input type="checkbox"/> cold feet and hands  | <input type="checkbox"/> problems with children    |
| <input type="checkbox"/> trouble sleeping        | <input type="checkbox"/> feeling panicky      | <input type="checkbox"/> problems with parents     |
| <input type="checkbox"/> feeling lonely          | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> poor physical health      |
| <input type="checkbox"/> loss of weight          | <input type="checkbox"/> shy with people      | <input type="checkbox"/> fighting and quarreling   |
| <input type="checkbox"/> not enjoying things     | <input type="checkbox"/> muscle twitching     | <input type="checkbox"/> dislike my body           |
| <input type="checkbox"/> suicidal thoughts       | <input type="checkbox"/> nausea or vomiting   | <input type="checkbox"/> full of energy            |
| <input type="checkbox"/> feeling inferior        | <input type="checkbox"/> can't make decisions | <input type="checkbox"/> overly ambitious          |
| <input type="checkbox"/> loss of sexual interest | <input type="checkbox"/> can't make friends   | <input type="checkbox"/> easily excited            |
| <input type="checkbox"/> no one understands me   | <input type="checkbox"/> headaches            | <input type="checkbox"/> quick tempered            |
| <input type="checkbox"/> worried about health    | <input type="checkbox"/> fainting spells      | <input type="checkbox"/> impatient with people     |
| <input type="checkbox"/> can't concentrate       | <input type="checkbox"/> unable to relax      | <input type="checkbox"/> binge eating              |
| <input type="checkbox"/> can't "get going"       | <input type="checkbox"/> feeling fearful      | <input type="checkbox"/> very restless             |
| <input type="checkbox"/> feeling angry           | <input type="checkbox"/> overly sensitive     | <input type="checkbox"/> feel like hurting someone |
| <input type="checkbox"/> don't like being alone  | <input type="checkbox"/> anxious inside       | <input type="checkbox"/> feel like smashing things |
| <input type="checkbox"/> lack energy             | <input type="checkbox"/> weight gain          | <input type="checkbox"/> excessive overeating      |

**Catherine Ellis, MA, LLP  
2001 Hudson Avenue  
Kalamazoo, MI 49008  
(269) 341-9725**

I welcome you to counseling and look forward to working with you. I believe the following information will be helpful in establishing a good therapy relationship between us. Please read this information carefully, and ask any questions that you have. When you have read both pages, please sign the statement on the back.

**Professional Background** I am a Limited Licensed Psychologist in Michigan, and a Nationally Certified Psychologist through the North American Masters in Psychology Organization. I am a Level II EMDR therapist, and a divorce and custody mediator. I am also a divorce coach and child specialist in collaborative divorce cases. My professional training has prepared me to help you deal with personal problems and relationship concerns. In addition to counseling, I offer workshops in health and wellness, stress management and music and healing.

I have been practicing in Kalamazoo since 1990, including fourteen years of experience at Child & Family Psychological Services. I also spent twenty-one years as a Disability Examiner for Social Security Disability. My master's degree is from Western Michigan University in Clinical Psychology.

**Initial Appointment** Your initial appointment is considered a diagnostic interview. From the information you share on this first visit, we will decide together whether I am the right therapist to help you attain your goals. If we decide to work together, we will discuss the type of therapy needed (individual, group, medication, etc.), the frequency of therapy sessions (weekly, bi-weekly, etc.), and schedule your next appointments.

**Appointments** Each therapy session lasts 45-50 minutes. All appointments are scheduled directly with me, in person or by phone. If you find that you need to cancel an appointment, please give as much notice as possible. You will be personally charged for appointments not canceled at least 24 hours in advance, except for emergency reasons. Insurance companies do not pay for unattended appointments.

**Payments** The fee for your initial visit is \$175 and for each therapy session thereafter is \$125. The fee for sessions involving conjoint treatment is \$135. Most insurance companies will pay for a portion of outpatient mental health services. With your approval by signature, I will bill your insurance company, and have the payments sent directly to me. You will be responsible for paying all deductibles and co-pays in full at each visit by cash or check. Because payment for your services is ultimately your financial responsibility, you should check carefully with your insurance company to find out the specific requirements of your coverage.

**Confidentiality** All information regarding the specific nature of your therapy is considered confidential, unless specified by you in writing. However, I do reserve the right to use specialty consultation with my supervisor, Karen Horneffer-Ginter, PhD, or other therapists as needed in regards to general aspects of therapy.

Therapists are required by law to break confidentiality and warn person(s) when a client behaves in such a way that poses a threat of physical harm to another person or to self. Michigan law also requires professionals to report suspected incidents of child abuse or neglect to the proper protective service agency.

**Termination** As you reach your goals in therapy, a gradual tapering of sessions will occur. It is helpful for you to discuss your wish to end counseling at least one or two sessions prior to your last session. A final session to process your therapy, settle any unfinished concerns, and say goodbye has proven to be beneficial.

**Emergencies** My confidential voicemail (269-341-9725) is always available for leaving messages when I am in session or out of the office. If an emergency arises when I am not available to speak with you, please call the Gryphon HelpLine (269-381-4357), which provides 24-hour crisis intervention services. The emergency room of the closest hospital is also another resource in time of crisis.

I encourage you to ask any questions you may have concerning the above policies, either now or as they occur.

Please circle:

- YES NO I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
- YES NO I have received a copy of this form and privacy practices brochure.
- YES NO I authorize the release of any medical information necessary to process my insurance claims.
- YES NO I authorize benefits to be paid directly to Catherine Ellis, MA.
- YES NO I consent to the exchange of treatment information between Catherine Ellis, MA and my primary care physician.

\_\_\_\_\_  
(Physician's name/office and phone number)

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_