Debra B. Agulnik, Ph.D. LMFT

Licensed Marriage and Family Therapist #000553-1

110 Ogden St. Ogdensburg, NY 13669

1-855-257-0848

Intake Form

Date:_____
Name(s):_____DOB:_____
_ Address:_____Zip
Code_____Phone:_____ SSN:_____ Cell
Phone:_____
email:_____
Emergency
Contact:_____Relationship:_____
Phone Number:_____
Physician:_____Phone
Number:_____ Physician
(Psychiatrist)_____Phone Number:_____ I,
_____, authorize Debra Agulnik, Ph.D. to discuss my case with my physician for the purpose of diagnosis and treatment planning. This authorization is good for one year from the date noted above unless revoked in writing by me. Signed:_____
Insurance:
Name of Insured_____Date of Birth of Insured:_____
SSN of Insured_____ Address (if
different)_____ Phone:_____
Insurance company:_____Policy
#_____Grp.#_____
Please provide a copy of both sides of your card or provide card to be copied at the 1st appt.

Reason for seeking counseling at this
time:_____ Goal(s) of
counseling:_____
___Previous counseling and with
whom:_____ Medical concerns and medication(s): Please included dosage, how long taken, and any side effects/reactions.

_____
Appetite: (Please check all applicable) ___loss of appetite ___decrease ___increase How many meals per day?____ Cravings?____If yes, for what?

_____
Sleep: (Please check all applicable) ____difficulty getting to sleep ____awakening during the night ___early rising. Average amount of sleep/night ____hours. Do you

feel rested upon arising? _____ Do you remember your dreams?_____If yes, content_____ Please indicate if you have had any of the following: ___Drug/Alcohol Use ___Eating Disorder ___Anger Problem ___Victim of Sexual/Physical/Mental Abuse ____Loss of Consciousness ___Depression ___Anxiety/Panic ___Adjustment Difficulties ___Disabilities If yes, type_____ ___thoughts of harming yourself___thoughts of harming others Education:
Highest level of education_____Any difficulties (social/learning/etc.)?
_____
__ Family History: Parents alive?_____married to each other?_____If not, your age when divorced_____. Remarried? _____Your age when remarried_____ Siblings: _____Brothers _____Sisters Where are you in the birth order? _____ Contact with Extended Family?
_____ Current marital status:
___Married (#___) Divorced___Widowed___Single Children? ___How many?
___ages:_____ Any custody issues? _____please explain:_____
_____
_____
If there are custody issues, please bring the most current court documents with you to the 1st session. Any Family History of PsychologicalPsychiatric Problems?
_____If so, who and extent_____
_____

Are there any family members you would like to participate in sessions with you?
_____If so, please indicate who and include contact information (by providing this information, you are authorizing Debra Agulnik, Ph.D. to discuss your case with any/all parties listed – please initial you understanding of this authorization ___)
Names/Relationship/Contact Information: _____]

Thank you for taking the time to fill out this form. I look forward to meeting with you.
My standard fee is $125 per 45-50 minute session (after the first session). Please be prepared to pay for your session on the day of your appointment. **If your insurance provider has authorized coverage, you will only be responsible for the co-pay at that time**. Please feel free to discuss an alternative fee if you are paying cash and cannot afford my standard fee. Please make sure to bring your insurance card so I can copy both sides.

Thank you! Debra B. Agulnik, Ph.D. LMFT