Brain & Behavior FITNESS

PATIENT INTAKE FORM

Patient Name: (Last) _____ (First) _____ (MI)_____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Email Address: _____

Education Level: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone:_____

Patient's Spouse: _____ Phone:_____

Family Physician: _____ Phone:_____

Referred by: _____

Have you ever been diagnosed with:

Traumatic Brain Injury? _____ If so, date and severity: _____

Mental Illness? _____ If so, date and diagnosis: _____

Have you ever been treated for a mental illness? _____
If so, what treatment did you receive and was it effective? _____

_____

_____

_____

Please make any comments that you think might be helpful: _____

_____

_____

_____

Do you currently have any medical concerns? Please list: _____

_____

_____

Brain & Behavior FITNESS

FINANCIAL POLICY

Thank you for selecting Brain & Behavior Fitness and Dr. Kraus for your mental health care needs. I am honored to be of service to you and your family. This is to inform you of my billing requirements and my financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements or prepayment packages have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

PATIENT'S SIGNATURE **DATE**

All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from Brain & Behavior Fitness and/or Dr. Kraus, I accept full liability from any consequences arising therefrom.

PATIENT'S SIGNATURE **DATE**