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COUNSELING

Adult Intake Form

CLIENT BACKGROUND INFORMATION

Please answer all of the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name:_____ Date of First Visit _____

Address: _____

Home Phone: _____ Work Phone_____

(May leave message: Yes No) (May leave message: Yes No)

Cell Phone: _____ (May leave message: Yes No)

Date of Birth_____/_____/_____ Age_____ SSN#_____

Email: _____ Referred by: _____

GUARANTOR INFORMATION

Guarantor Name: _____ D.O.B. _____

Guarantor Address:

_____

Home Phone: _____ SSN: _____ Relation to Pt. _____

Guarantor Employer: _____ Work Phone: _____

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Insurance Company Name/Phone Number: _____

Member ID/Policy Number _____

Group Number: _____

Assignment of Benefits: I hereby authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to **Veda Doubleday MS, LPC, NCC** for the services provided.

Guarantor Signature _____ Date _____

GENERAL INFORMATION

Clients' current household: List by Household your current family

Primary Household (anyone who currently lives with you)

Name Age Gender Relationship to child (Include step, half, etc.)

_____

_____

_____

_____

_____

CLIENT HEALTH

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Primary Care Physician:

_____

Name Phone

Physical Disability: Yes No (If yes, explain)

_____

Chronic Illness: Yes No (If yes, explain)

_____

Terminal Illness: Yes No (If yes, explain)

_____

What medication are you currently taking?

Medication Dosage Purpose

_____

_____

_____

_____

_____

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Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

If yes: Previous Mental Health Agency or Therapist _____

Phone_____ Dates of Service_____(beginning - ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When _____

Where_____

FAMILY HISTORY/EXPERIENCES

Current Family Stressors:

____ Chronic illness of family member

____ Death of significant person

____ Domestic Violence

____ Family member absent (explain)_____

____ Family member's disability/major accident/illness

____ Family member emotional problems (explain)_____

____ Family member suicide (explain) _____

____ financial problems

____ Moved a lot

____ Frequent Arguing

____ Divorce

____ Other _____

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History of emotional/behavioral problems: Yes No

(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No

(If yes, please explain) _____

History of family violence: Yes No

(If yes please explain) _____

History of criminal activity: Yes No

(If yes, please explain) _____

CURRENT CONCERNS

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Please mark the following items that apply.

___Abuse (physical, emotional, sexual)

___Adjustment to life changes (moving, getting married or divorced, aging, etc.)

___Drug or alcohol use (both legal and illegal drugs)

___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)

___Family or Stepfamily relationship problems

___Feeling angry or irritable

___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)

___Feeling sadness or depression NOT related to grief

___Feeling sadness or depression related to grief

___Health concerns (physical complaints and/or medical problems)

___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)

___Non-family relationship problems (co-workers, peers, etc.)

___Parent-Child relationship (discipline, adoption, single parent, etc.)

___Sexual concerns (loss of interest, excessive masturbation, inappropriate acting out)

___Sleep problem (nightmares, sleeping too much or too little, etc.)

___Suicidal Ideation (thoughts of death, wanting to die)

___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)

___Other (explain)_____

ALCOHOL & SUBSTANCE USE INFORMATION

How often and **how much** do you consume alcoholic beverages?

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Client 1: _____

Client 2: _____

Do you smoke marijuana or use other “street drugs” (please remember this information is strictly confidential).

Client 1: _____

Client 2: _____

Briefly describe the problem that has brought you to therapy

_____
_____
_____

What are your goals of therapy?

_____
_____

_____