ADULT INTAKE FORM

PATIENT INFORMATION

Full Legal Name (First, Middle Initial, Last) :

_____

Address:

_____

City, State, Zip:

_____

Sex: Male _____ Female_____ Other _____ Date of Birth:_____

Social Security Number: _____

Email:

_____

_

Home Phone: _____ Cell Phone:

_____

Work Phone: _____ Referred by:

_____

EMERGENCY CONTACT INFORMATION

Name: _____ Cell Phone:

_____

Address:

_____

City, State, Zip:

_____

Relationship:

_____

GENERAL INFORMATION

Employment Status: _____

Is Condition related to a work-related or motor vehicle accident: Yes _____ No

_____

If yes, please explain:

_____

_____

_____

INSURANCE INFORMATION – (Complete information below with Policyholder information)

Full Legal Name (First, Middle Initial, Last) :

_____

Address:

_____

City, State, Zip:

_____

Sex: Male _____ Female_____ Other _____ Date of Birth:_____

Social Security Number: _____

Patient's Relationship to Policyholder (Spouse, child, etc.)

_____

Policyholder Employer:

_____

Is this covered under Employer's Employee Assistance Program (EAP)? Yes _____ No _____

EAP Contact Name: _____ Phone:

_____

EAP Authorization Number;

_____

AUTHORIZED SIGNATURES:

I consent to the release of medical information other information necessary to process this claim; I also request payment of government benefits, either to myself of the party below.

_____

_____

Signature Date

I authorize payment of medical benefits to the undersigned physician or supplier of services.

_____

_____

Signature Date

PLEASE COMPLETE AS THOROUGLY AS POSSIBLE

MARITAL STATUS

Married _____ Cohabitating _____ Divorced _____ Widowed _____ Separated _____ Single

CHILDREN

Names and ages:

_____

_____

_____

_____

_____

PERSONS LIVING IN YORU HOME

Names and ages:

_____

_____

_____

_____

_____

RELIGIOUS AFFILIATION

Religion: _____ Active in Church: _____ yes _____ no

EDUCATION

Highest level of education completed: _____ Degree _____ yes _____ no

COUNSELING HISTORY, NEEDS AND GOALS

Have you participated in counseling in the past? _____ yes _____ no

If yes, Location

_____

When _____ How long did you participate? _____

Do you feel the counseling was helpful? _____ yes _____ no

Location

_____

When _____ How long did you participate? _____

Do you feel the counseling was helpful? _____ yes _____ no

Location

_____

When _____ How long did you participate? _____

Do you feel the counseling was helpful? _____ yes _____ no

BRIEFLY EXPLAIN WHY YOU ARE SEEKING HELP NOW:

_____

_____

_____

_____

_____

_____

_____

Are you currently having suicidal or homicidal thoughts? _____ yes _____ no

Have you ever made a suicide attempt? If so, please explain: _____ yes _____ no

_____

_____

_____

_____

Has anyone close to you ever attempted suicide or homicide? If so, please explain: _____ yes _____ no

_____

_____

_____

_____

Do you worry about your safety in your current living situation? If so, please explain: _____ yes _____no

_____

_____

_____

_____

Have you ever struck or threatened people or animals or damaged property in anger? If so, please explain: _____ yes _____ no

_____

_____

_____

_____

_____

PLEASE CHECK THE FOLLOWING WORDS THAT YOU FEEL APPLY TO YOU:

□ Social/Outgoing	□ Assertive	□ Impulsive	□ Unattractive

□ Intelligent	□ Not easily depressed	□ Out of control	□ Can accept love from
□ Self-Controlled	□ Mostly able to relax	□ Can't concentrate	others
□ Resourceful	□ Liked by others	□ Unimaginative	□ Worthwhile/"good
□ Creative	□ Patient	□ Full of hate	enough"
□ Can forgive	□ Respectful of others	□ Isolated/Loner	□ Tense most of the
□ Can ask for help	□ Perfectionist	□ Bottled up	time
□ Can express feelings	□ Have enough money	□ Unstable	
□ Stable	□ Shy/Backward	□ Passive/Pushover	
□ Secure	□ Stupid/Dumb	□ Easily discouraged	
□ Faithful	□ Insecure	□ Not liked by others	
□ Physically active	□ Unfaithful	□ Impatient/Edgy	
□ Motivated	□ Lazy	□ Disrespectful	
□ Happy	□ Unmotivated	□ Financially Stressed	
□ Confident	□ Depressed	□ Worthless	

Other words you feel apply to you:

_____

_____

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING EVENTS YOU HAVE EXPERIENCED WITHIN THE LAST YEAR:

□ Death of a spouse or child	□ Minor violations of the law
□ Death of a close friend	□ Major change in the amount of arguments you
□ Death of a close family member	have with your spouse (ex: a lot more or less)
□ Divorce	□ Major change in the health or behavior of a
□ Marital Separation	family member
□ Detention in jail or other institution	□ Major change in responsibility at work (ex: a
□ Major personal injury or illness	promotion, transfer, demotion)
□ Marriage	□ Major change in the usual type and/or amount
□ Fired from employment	of recreation
□ Marital Reconciliation	□ Major change in church or spiritual activities
□ Retirement	(more or less that usual
□ Pregnancy of spouse/partner	□ Taking on a small loan (ex: purchasing a car or

□ Sexual Difficulties	home repairs)
□ Gaining a new family member (ex: birth)	
□ Major business readjustment (ex: merger)	□ Major change in sleeping habits (ex: either a lot
□ Major change in financial state (better or worse)	more or less)
□ Changing to a different type of work	□ Major change in the number of family
□ Taking on a significant (to you) mortgage	get-togethers (a lot more or less)
□ Foreclosure on mortgage or loan	□ Major change in eating habits (a lot more or a
□ Son or daughter left the home	lot less food intake)
□ In-law troubles	
□ Outstanding personal achievements	
□ Work status change for spouse/partner	
□ Beginning or ending of formal schooling	
□ Major change in living conditions	
□ Change of personal habits (ex: dress, manners)	
□ Trouble with your boss	
□ Change in residence	
□ Changing to a new school	
□ Major change in social activities	
□ Holiday or vacation	
□ Christmas	

PLEASE CHECK ANY OF THE FOLLOWING ISSUES YOU ARE CURRENTLY EXPERIENCING:

□ Custody Issues	□ Infidelity/unfaithful partner	□ Anxiety
□ Behavior of adult children	□ Distance from loved one	□ Depression
□ Health problems in family	□ Gambling	□ Financial difficulty
□ Personal health problems	□ Anger problems	□ Grief
□ Substance abuse/ dependence	□ Parenting problems	□ Family relationship issues
□ Excessive computer use	□ School problems	□ Problems with pornography
□ Interpersonal problems	□ Victim of physical abuse	□ Victim of sexual abuse

PLEASE CHECK ANY OF THE SYMPTOMS BELOW WHICH APPLY TO YOU:

PHYSICAL	EMOTIONAL	THOUGHTS	BEHAVIORS
□ Headaches	□ Sadness	□ Memory problems	□ Use of drugs or
□ Bowel/Stomach	□ Worry	□ Paranoia	alcohol
□ No appetite	□ Overexcited	□ Confusion	□ Avoiding loved ones
□ Dizziness	□ Agitated	□ Repetitive thoughts	□ Missing work or
□ Tremors	□ Panicky	□ Racing thoughts	school
□ Muscle weakness	□ Nervous	□ Attention problems	□ Laugh and/or cry

□ Fainting spells	□ Empty	□ Thoughts of escape	inappropriately
□ Shortness of breath	□ Grieving	□ Decision problems	□ Nervous habits (ex:
□ Hair/Skin problems	□ Despair	□ Poor judgement	biting nails)
□ Jaw pain	□ Hopelessness	□ Hallucinations	□ Losing temper
□ Reproductive	□ Fits of rage	□ Disorganized	□ Becoming violent
problems	□ Jealousy	thinking	□ Risky behaviors
□ Sexual problems	□ Moodiness	□ Other: _____ __	□ Grinding teeth
PHYSICAL	**EMOTIONAL**	**THOUGHTS**	**BEHAVIORS**
□ Excessive sweating	□ Desire to cry	□ Other: _____	□ Less/More sexual
□ Heart problems	□ Resentment	_____	Contact
□ Heart races/pounds	□ Frustration	_____	□ Less/More sleeping
□ Nausea	□ Inadequacy	_____	Other: _____
□ Fatigue	Other: _____	_____	_____
Other: _____	_____	_____	_____

SOCIAL HISTORY

Please list length of marriage(s)/Live-In(s):

_____
_____
_____
_____
_____

Please describe your family of origin (name and ages of parents and siblings):

_____
_____
_____
_____

Have you experienced any traumatic events or significant loss?

_____
_____
_____
_____

Please describe any significant legal history:

_____
_____
_____
_____

MEDICAL HISTORY

Family Physician _____ Date of last examination _____

PLEASE CHECK ANY ILLNESS YOU HAVE, OR HAVE HAD IN THE PAST:

□ Diabetes Type 1	□ Diabetes Type 2	□ Asthma
□ Arthritis	□ Pneumonia	□ Ulcer
□ Seizures	□ Alcohol/Drug problems	□ High blood pressure
□ Low blood pressure	□ Heart disease	□ Thyroid disease
□ Tuberculosis	□ Colitis	□ Nerve disorder
□ Lung Disease	□ Cancer	□ Kidney disease
□ Hepatitis	□ Cirrhosis	□ Bone disorder
□ Anorexia	□ Venereal disease	□ Head injuries
□ Other injuries	□ Muscular disorder	□ Obesity
□ AIDS/HIV	□ Fibromyalgia	Other: _____

Is there any history of depression, mental illness or alcohol/drug problems in your immediate family? _____ Yes _____ No If yes, please explain:

_____
_____
_____
_____
_____
_____

Currently prescribed medications:

NAME	DOSE	PURPOSE	SIDE EFFECTS?

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications:

NAME	DOSE	PURPOSE	SIDE EFFECTS?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? _____yes _____no If yes, explain:

_____

_____

_____

_____

_____

_____

Significant family medical history?

_____

_____

_____

_____

_____

_____

	DATE	REASON	RESULTS
Last physical exam:	_____	_____	_____
Last doctor's visit:	_____	_____	_____
Most recent surgery:	_____	_____	_____
Upcoming Surgeries	_____	_____	_____
Past surgeries	_____	_____	_____

CHEMICAL USE HISTORY

TYPE	METHOD OF USE	AMOUNT EACH USE	HOW OFTEN USED	AGE FIRST USED	AGE LAST USED	USED IN LAST 48 HOURS		USED IN LAST 30 DAYS	
						YES	NO	YES	NO
Alcohol									
Barbiturates									
Valium									
Cocaine									
Crack									
Heroin									
Opiates									
Marijuana									
PCP/ LSD									
Mescaline									
Inhalants									
Caffeine									
Nicotine									

Over-the-Counter									
Prescription Drugs									
Other									

Substance of Preference:

- _____ 3. _____
- _____ 4. _____

Describe when and where you typically use substances:

_____
_____
_____
_____
_____

Describe any changes in your use patterns:

_____
_____
_____
_____
_____

Describe how your use has affected your family and/or friends (including their perceptions of your use):

_____
_____
_____
_____
_____

Reason(s) for substance abuse:

_____ Addicted _____ Builds Confidence _____ Escape _____ Self-Medication
_____ Socialization _____ Taste _____ Other (Specify)
_____
_____
_____
_____
_____

How do you believe your substance abuse affects your life?

_____
_____
_____
_____

_____

Please answer YES or NO to the following four questions:

- Have you ever thought about cutting back on your alcohol/substance use? _____
- Have you ever been annoyed at others' comments about your substance use? _____
- Have you ever felt guilty about the level of your alcohol/substance use? _____
- Have you ever used alcohol/substances first thing in the morning to steady your nerves or get rid of a hangover?

  _____

Who or what has helped you in stopping or limiting your use?

_____

_____

_____

_____

_____

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder by email, text message or phone call a day before your scheduled appointment. You can also schedule online at any time. Once your account is established you simply visit www.therapyappointment.com. If you want to utilize this service, please complete the following:

Requested Login Name:

_____

Requested Password:

_____

Your Email Address: _____ @

_____

Your Cell Phone Number:

_____

Your Home Phone Number:

_____

Where would you like to receive appointment reminders (check one)

_____ via standard text message

_____ via email

_____ via automated phone call to my cell phone number

_____ via automated phone call to my home phone number

_____ None of the above; I'll remember my appointments on my own (missed appointment fees will apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By

signature below I’m waiving my right to keep this information completely private, and requesting that it be handled as I have noted above

_____

_____

Signature Date

*****PLEASE RECORD YOUR LOGIN AND PASSWORD INFORMATION FOR YOUR RECORDS*****