Tiffany Thibodeaux, LPC, NCC
Professional Counselor for Adults & Adolescents

Adult Intake & History

Please fill out this form and bring it to your first appointment

Personal Information			
Name	Date of Birth	Gender M F	
Address	City/Zip		
Cell ( )	Work ( )	Text Appointment Reminders? Y N	
Email	Email Appointment Reminders? Y N		
Occupation	Name of Employer		

Contact Information	
Relationship Status Single Married Divorced Long Term Relationship Other:	
Spouse/Partner Name	Phone Number ( )
Emergency Contact	Emergency Phone ( )

How did you hear about Tiffany? _____

_____ Private Pay **_____ Blue Cross Insurance** **_____ Other Insurance**

INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID #_____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Please note: You are required to verify your benefits before attending your first appointment. Our office will not know your exact benefits & coverage until we receive an explanation of benefits from your insurance company after the first billing.

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Therapy Information		
Name	Date of Birth	Date
Describe the reason you are seeking counseling.		
How long has this problem been going on?		
Have you experienced any major stressors in the last year*? (ex: death of a loved one, major illness, move of home or school, divorce, trauma, loss of employment, abuse, or major life change?)*		
What would you like to accomplish in counseling?		
List some of your strengths and weaknesses		
Conditions that you have been diagnosed with □ Depression □ Anxiety □ Bipolar □ OCD □ Schizophrenia □ ADD/ADHD □ Borderline Personality □ Other		

Medical Information	
Primary Care Physician	Phone Number
List any important medical history, chronic ailments, or other health problems.	
Do you take medication for physical or psychiatric conditions? If yes please list medication below	

Name of Medication	Dosage	Condition Treated	Prescribing Physician

List any psychiatric medications that you have taken in the past.

Education and Employment			
Employer		Job Title	
Job Duties			
Are you happy with your job? □ Yes □ No		Are you currently in school? □ Yes □ No	
School Name		Major	
Highest Level of Education Completed			

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Family Information				
Are you currently in a romantic relationship? □ Yes □ No				Marital Status
Length of relationship?		How happy are you with your relationship?		
Do you have children? if so please list name(s), gender, and ages				
Explain your living arrangements: *(People who live in your home, children's living arrangements, split custody etc.)*				
Who were your primarily raised by?				
Relationship with Mother during childhood	□ Good	□ OK	□ Poor	Still living? □ Yes □ No
Current Relationship with Mother	□ Good	□ OK	□ Poor	
Relationship with Father during childhood	□ Good	□ OK	□ Poor	Still living? □ Yes □ No
Current Relationship with Father	□ Good	□ OK	□ Poor	
Sibling(s) names and age(s)				
Who are the other important people in your life that you depend on for emotional support? (include friends, family members, religious organizations, clubs etc.)				

Answer the following		Please explain all yes answers
Do you drink alcohol more than once a week?	□ Yes □ No	Amount consumed per week
Do you, or have you in the past, engaged in recreational drug use?	□ Yes □ No	Types of drugs used
Have you ever felt the need to cut down on your drinking or drug usage?	□ Yes □ No	
Do you currently have outstanding legal charges or court dates?	□ Yes □ No	Explain
Is anyone requiring you to attend counseling?	□ Yes □ No	Person, Court, or Facility
Have you ever been arrested or incarcerated?	□ Yes □ No	Dates and offense
Have you ever been physically, emotionally, or sexually abused?	□ Yes □ No	As a child □ As an adult □
Is there currently domestic abuse in your relationship?	□ Yes □ No	Explain

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Answer the following		Please explain all yes answers
Have you ever tried to kill yourself or someone else?	□ Yes □ No	Details Date
Are you currently having thoughts of suicide?	□ Yes □ No	
Do you have problems sleeping?	□ Yes □ No	□ Problems Falling Asleep □ Problems Staying Asleep
Do you consider yourself to be religious or spiritual?	□ Yes □ No	Religion Level of involvement

Mental Health History		
Have you ever received a mental health diagnosis?	□ Yes □ No	Diagnosis Physician Name Year
Have you ever attended counseling before today?	□ Yes □ No	Reason for attendance Therapist name Dates Outcome: □ Successful □ No Change □ Worse
Do you currently see a psychiatrist or other professional who prescribes medication?	□ Yes □ No	Physician name:
Have you ever had a psychiatric evaluation?	□ Yes □ No	Reason Physician Name Year
Have you ever been hospitalized for a psychiatric condition, drug or alcohol abuse, an eating disorder, self-injurious behaviors, or suicidal ideation?	□ Yes □ No	Reason Name of Facility Date(s) Outcome: □ Successful □ No Change □ Worse
Do you have any close relatives (parents, siblings, grandparents) who have experienced a mental health condition including depression, anxiety, bi-polar disorder, OCD & Schizophrenia?	□ Yes □ No	List relationship and diagnosis
Do any close relatives (parents, siblings, grandparents) have or have had drug or alcohol abuse problems?	□ Yes □ No	List relationship and substance(s) used

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Concerns Checklist

Please read this list and check all issues that <u>are or have been</u> a concern to you.
Circle the 3 issues that are the most concerning to you at this time.

☐ Abuse/Neglect as a child	☐ Hallucinations	☐ Physical Appearance
☐ ADD/ADHD	☐ Hates being alone	☐ Poor attention/concentration
☐ Alcohol/Drug Use	☐ Headaches	☐ Post-Partum Depression
☐ Anger Problems	☐ Health Problems	☐ Pre-marital counseling
☐ Anxious or Nervous	☐ Homicidal Thoughts	☐ Racing Thoughts
☐ Appetite problems	☐ Hopelessness	☐ Relationship problems
☐ Binge Eating	☐ Isolation from others	☐ Restlessness/on edge
☐ Blended Family Issues	☐ Lack of Friends/ Loneliness	☐ Sadness
☐ Can't Say no	☐ Lack of Motivation	☐ School Issues
☐ Chronic Pain	☐ Legal Problems	☐ Self-Injury
☐ Confusion about identity	☐ Loss of interest in activities	☐ Sex related problems
☐ Depression	☐ Low Self Esteem	☐ Sexual Orientation Issues
☐ Difficulty making decisions	☐ Lying or stealing	☐ Shyness
☐ Divorce	☐ Major life Change	☐ Sleep Problems
☐ Domestic Violence	☐ Memory Problems	☐ Social Anxiety
☐ Dysfunctional Childhood	☐ Mood Swings	☐ Spirituality Issues
☐ Eating Disorder	☐ Negative thoughts/outlook	☐ Stress
☐ Experienced Trauma	☐ Nightmares	☐ Thoughts get stuck in your head
☐ Fatigue/low energy	☐ OCD behaviors	☐ Tired all of the time
☐ Financial problems	☐ Panic Attacks	☐ Trouble throwing things away
☐ Flashbacks	☐ Paranoia	☐ Trust Issues
☐ Gambling	☐ Parent Child Conflict	☐ Victim of Rape
☐ Grief/loss	☐ Phobias	☐ Work problems/issues

NOTES: _____

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Signature _____ *Date* _____