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

Adult Intake & History

Personal Information			
Name	Date of Birth	Gender	
Address	City/Zip		
Cell	Work	Text Appointment Reminders? ☐ Y ☐ N	
Email	Email Appointment Reminders? ☐ Y ☐ N		
Race/Ethnicity	Do you need accommodations for a disability? ☐ Y ☐ N		

Additional Contact Information	
Spouse/Partner Name	Phone Number
Emergency Contact	Emergency Phone

How did you hear about Tiffany? _____

INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID #_____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Our office will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware, this is only "A QUOTE of Benefits/Authorizations." We cannot guarantee payment or verify that the eligibility or benefits conveyed to us, or to you, will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service. Our office will not know your exact coverage until the claim is processed and we receive an explanation of benefits from your insurance company.

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Therapy Information		
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		
Do you consider yourself to be religious or spiritual?	☐ Yes ☐ No	Religion Level of involvement

Mental Health History		
Conditions that you have been diagnosed or treated for: ☐ ADD/ADHD ☐ Anxiety ☐ Bipolar Disorder ☐ OCD ☐ Depression ☐ Borderline Personality Disorder ☐ Schizophrenia ☐ Learning Disability ☐ Other _____		
Physician Name		Year
Have you attended counseling before today?	☐ Yes ☐ No	Reason for attendance: Therapist name: Dates: Outcome: ☐ Successful ☐ No Change ☐ Worse
Do you currently, or have you in the past seen a physician or psychiatrist who prescribes psychiatric medication?	☐ Yes ☐ No	Physician name: Medications:
Have you ever had a psychiatric evaluation?	☐ Yes ☐ No	Reason: Physician Name: Year:
Have you ever been hospitalized for a mental health 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
Have you ever attempted suicide?	☐ Yes ☐ No	Details: Date(s):
Are you currently having thoughts of suicide?	☐ Yes ☐ No	Explain:
Do you have problems sleeping?	☐ Yes ☐ No	☐ Problems Falling Asleep ☐ Problems Staying Asleep

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Mental Health History Continued		
Have you experienced any traumatic events in your life? (ex: flooding, fire, witness of a crime, member of military)	☐ Yes ☐ No	Explain:
Do you have any close relatives (parents, siblings, grandparents, children) who have experienced a mental health condition?	☐ Yes ☐ No	List relationship and diagnosis -

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(s) below.	

Name of Medication	*Dosage*	*Condition Treated*	*Prescribing Physician*

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

Abuse		Please explain all yes answers
Do you drink alcohol?	☐ 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	Explain:
Do any close relatives (parents, siblings, grandparents, children) who have or have had drug or alcohol abuse problems?	☐ Yes ☐ No	List relationship and substance(s) used:
Have you ever been physically, emotionally, or sexually abused?	☐ Yes ☐ No	As a child ☐ As an adult ☐
Is there currently abuse in your household or relationship?	☐ Yes ☐ No	Explain:

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Family Information					
Who were your primarily raised by?					
Relationship with Mother - During childhood	☐ Good	☐ OK	☐ Poor	Still living?	
Current Relationship	☐ Good	☐ OK	☐ Poor	☐ Yes	☐ No
Relationship with Father - During childhood	☐ Good	☐ OK	☐ Poor	Still living?	
Current Relationship	☐ Good	☐ OK	☐ Poor	☐ Yes	☐ No
Sibling(s) names and age(s)					
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 are the important people in your life that you depend on for emotional support? *(include friends, family members, religious organizations, clubs etc.)*					

Birth & Development	
Were than any problems with your Mother's pregnancy or at birth? Explain	☐ Yes ☐ No
Did you have any developmental delays (walking or talking), Any educational concerns? Learning disabilities? IEP/Special Education?	☐ Yes ☐ No

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			

Legal History		
Do you currently have outstanding legal charges, pending litigation, 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:

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Patient Concerns

Please read this list and check all issues that ARE or Have Been a concern to you.

☐ 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	☐ School Issues
☐ Can't Say no	☐ Lack of Motivation	☐ Self-Injury
☐ Chronic Pain	☐ Legal Problems	☐ Sex related problems
☐ Confusion about identity	☐ Loss of interest in activities	☐ Sexual Orientation Issues
☐ Depression/Sadness	☐ Low Self Esteem	☐ Sleep Problems
☐ Difficulty making decisions	☐ Lying or stealing	☐ Social Anxiety
☐ Divorce	☐ Major life Change	☐ Suicidal Thoughts
☐ Domestic Violence	☐ Memory Problems	☐ Suicide Attempts
☐ 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:

Signature _____ *Date* _____

Clear Form