New_____ Re-Admit___X_____

Client Intake Information

Date_____

THIS SHEET MUST BE FILLED IN COMPLETELY

First Name_____ Last Name_____ MI__
Address_____ City_____ State_____ Zip_____
Telephone (Home)_____ (cell)_____
E-Mail:_____
Birthdate___/_____/_____ Age_____ Gender:_____ Race/ethnicity_____

Employment Information

Place_____Phone_____Can we leave messages? Y / N

Name of Spouse/Guardian_____Phone_____
Address_____ City_____ State_____ Zip_____

Person Responsible for scheduling appointments, maintaining insurance-copay-deductible-and/or payment:
Name: _____ SS#:_____
Signature of Responsible party **X**_____(Must be signed for services to begin)

Insurance Information

Primary Insurance_____Secondary Insurance_____
Phone_____Phone_____
Contract/ID#_____Contract/ID#_____
Group/Acct#_____Group/Acct#_____
Subscriber_____Subscriber_____
Subscriber Date of Birth_____Subscriber Date of Birth_____
Employer_____Employer_____
Client's relationship to Subscriber Client's relationship to Subscriber
__Self __Spouse __Child __Other_____ ___Self __Spouse __Child __Other_____

Emergency Information

In case of emergency, contact:
Name _____ Phone_____Relationship_____
Address_____ City_____ State_____ Zip_____

Current Medications_____
Allergies_____

Referral Source

How did you hear of our clinic (or from whom)?_____
Address_____ City_____ State_____ Zip_____
Phone_____ Relationship to referral source_____

Name:_____Date of Admission:_____

Please list any other professionals you are currently (or within the last year) working with:

Medical Doctor

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Psychiatrist/psychologist

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Probation officer

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Previous counselor

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Mental health hospitalization

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Other

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

***Note**: The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above named person's written consent, specifying the release of this information in accord with Federal regulations.*

A separate release of information will be signed if you indicated ***Yes*** on any of the above.

Name:_____Date of Admission:_____

Presenting Problem (s):

Check any areas of your life or problems you are currently experiencing:

☐ Marriage	☐ Finances	☐ Depression	☐ Domestic Violence
☐ Family	☐ Employment	☐ Suicidal thoughts	☐ Physical/sexual abuse
☐ Parents	☐ Self Esteem	☐ Anxiety/ Panic	☐ Pornography
☐ Parenting	☐ Religious/spiritual	☐ Eating disorder	☐ Gambling (complete SOGs)
☐ Relationships	☐ Communication	☐ Health Concerns	☐ Alcohol (complete MAST)
☐ School	☐ Grief	☐ Legal Problems	☐ Drugs

(If alcohol or drugs are checked please complete PHQ Substance use questionnaire)

Briefly describe the problem (s) you are having at this time:

_____

_____

_____

_____

_____

_____

_____

Answer the following questions and note any differences in your situation between now and your last appointments:

Have you received counseling or been hospitalized for these or other problems since your last appointment? Yes No

If yes, when and where:

_____

_____

Since your last visit have you considered ☐ made a plan ☐ attempted suicide? ☐ Yes No

Explain:_____

_____

Family / Social Developmental History:

Has there been any changes in your extended family since last appointments? Yes No

Have you been abused since last appointments (check all that apply)? Yes No

☐ Verbally ☐ Emotionally ☐ Mentally ☐ Physically ☐ Sexually

If yes, when and by whom?:_____

_____

Was anyone else in your family abused? Yes No

_____

Have you self-harmed? Yes No How? _____

_____

Name:_____Date of Admission:_____

Your Marriages and Significant Relationships:

Any changes in your current relationships with your significant other or children?

Name Problem

_____

_____

_____

Social/Peers:

Any changes in your current relationships with Peers or socially? Yes No

Name Problem

_____

_____

_____

List any current recreational activities, interests and hobbies, organizations or community activities you pursue: _____

_____

Educational Background:

Any changes in your education? Yes No

If yes, when, where and for what?:_____

Military History:

Any changes in your military experience? Yes No

If yes, when, where and how?:_____

_____

Employment/Financial History:

Any changes in your employment? Yes No Any recent unemployment? Yes No

Current Employer/Occupation:_____

Dates of employment:_____ Level of job satisfaction:_____

If yes, when, where and for what?_____

_____

Who do you live with?_____Do they help financially? ☐ Yes ☐ No

Legal History:

Any changes in your employment? Yes No

If yes, please explain:_____

_____

Name:_____Date of Admission:_____

Religious/Spiritual Background:

Any changes in your spirituality? Yes No

Do you currently practice your spirituality/religion?: ☐Yes How?_____ ☐No

Elaborate on previous questions or other information pertinent to your therapy:_____

_____

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Treatment Plan

List two or three goals you would like to achieve in therapy:

#1. _____

#2._____

#3._____

Name:_____Date of Admission:_____

Family History

	Name	Currently Living?	*Significant health, medical, dental or mental health problems*
Spouse:	_____	Y / N	_____
Children:	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
Siblings :	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
Mother :	_____	Y / N	_____
Father :	_____	Y / N	_____

Personal Past and Present Medical/Emotional Health History (dates of treatment and hospitalizations) since last appointment:

_____

_____

_____

_____

Allergies:_____ Drug allergies:_____

Current Physician: _____Date of last office visit/exam: _____

Address: _____Phone:_____

Prescription and non-prescription drugs used in the last year: Write additional on back of sheet if needed.

Drug, Dose, Frequency	Physician	Start date and reason	Stop date and reason

Height: _____ Weight: _____ Satisfaction with appearance: Low Medium High

Recent Change in Weight? ____Y _____N _____Increase _____Decrease Dieting? ____Y ____N

Recent Change in Appetite? _____Y _____ N _____Increase _____Decrease

Any eating disorder? _____ Anorexia _____Bulimia _____ Binge eating _____Body dysmorphia

Sleep disturbances: ☐ None ☐ Insomnia ☐ Frequent Waking ☐ Decreased ☐ Restlessness

☐Increased ☐Nightmares ☐ Sleep apnea ☐ Narcolepsy ☐ Sleep Walking ☐ Other:_____

Drug history (past and present): ___ Nicotine ___ Alcohol ___ Caffeine ___ Other

Frequency_____

Please rate your overall health: ___ Poor ___ Fair ___ Good ___ Excellent _____