

Client Intake Information	Date _____
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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 Parent/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 __ Self __ Spouse __ Child __ Other _____	Client's relationship to Subscriber __ 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 (42CFR11). 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.*

Name: _____ Date of Admission: _____

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

Presenting Problem (s):

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> School | <input type="checkbox"/> Self Harm | <input type="checkbox"/> Depression | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Family | <input type="checkbox"/> Employment | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Physical/sexual abuse |
| <input type="checkbox"/> Parents | <input type="checkbox"/> Self Esteem | <input type="checkbox"/> Anxiety/ Panic | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Religious/spiritual | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Friends/peers | <input type="checkbox"/> Communication | <input type="checkbox"/> Health Concerns | <input type="checkbox"/> Alcohol and/or drugs |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Grief | <input type="checkbox"/> Anger control | <input type="checkbox"/> Gambling |

(If alcohol or drugs is checked please complete the 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? _____

Have you or any family member been adopted, or placed in foster care? Yes No

Name: _____ Date of Admission: _____

Explain if yes:

Primary Caregiver: Bio parents Bio Mom Bio Dad Bio Mom and step Dad/boyfriend
 Bio Dad and step Mom/girlfriend Adoptive Parent Grandparent (s) Foster Family
 Other _____ Current Caregiver (if different from above): _____

Are they able to support the family financially? Yes No _____

Place of Residence: House Apartment Trailer Condo Agency Housing Other _____

Father's Occupation: _____ Mother's Occupation: _____

Any changes in your current relationships with your parents or siblings?

Name Problem

Is either parent/caregiver experiencing a problem with Alcohol Drugs Violence

If yes, please explain: _____

Parental discipline was administered by whom?: _____ How?: _____

List any significant events/adjustments/deaths since your last appointment: _____

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: _____

Favorite TV shows: _____

Favorite movies: _____

Favorite books: _____

Favorite video games: _____

Educational Background:

Any changes in your education? Yes No

Current Grade: _____ School: _____ Average GPA: _____

School Status: Regular Classes Honor Classes Resource/Special Ed Home Schooled

Name: _____ Date of Admission: _____

Have you been diagnosed with any learning disorders? Yes No

Please explain how they affect school performance: _____

Do you have plans to further your education? Yes No

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

Employment: (if not applicable skip to next section)

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

Religious/Spiritual Background:

Any changes in your spirituality? Yes No

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

Legal History:

Any changes in your employment? Yes No

If yes, please explain: _____

Personal Information:

Do you have any physical or psychological developmental problems? Yes No

Current thoughts of Violence: None Self Injury Others (Who? _____)

Current or recent past Risk-Taking Activities: None Shoplifting Purse Snatching Theft

Abuse Breaking&Ent Burglary Sexual Promiscuity Drug Use/Possession Drug Sales

Have you viewed pornography in the last 6 months? Yes No

If Yes, in which form _____ Internet _____ magazines _____ other

Drugs used: Caffeine Alcohol Marijuana Nicotine Other (illicit/OTC): _____

Self Esteem: Very Positive Positive Mixed Negative Very Negative

What are some positives in your life and your positive qualities?: _____

What are some negatives in your life and your negative qualities?: _____

Name: _____ Date of Admission: _____

Family History

Name	Currently Living?	<i>Significant health, medical, dental or mental health problems</i>
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 _____