Jackson Counseling Solutions LLC
Client Intake

Intake Appt _____

Client Information:

Name (legal): _____ Date of Birth: _____

Preferred Name: _____ Age: _____

Administrative Sex: Male Female Gender (as listed with insurance) Male Female

Marital Status: single married divorced widowed other

Address:_____

_____

Employment: unemployed part-time employed full-time student retired

Contact Information: **Please indicate if okay to leave text or voicemails related to:**

Phone #: _____ Appointments: yes no Clinical information: yes no
Work #: _____ Appointments: yes no Clinical information: yes no
Email: _____ Appointments: yes no Clinical information: yes no

Would you like an email to join the Patient Portal which grants you free access to attend Virtual/Telehealth appointments? Yes No

Parent/Guardian Information (*if client is a minor*):

Name: _____ Phone #: _____ Relationship to Client: _____
Name: _____ Phone #: _____ Relationship to Client: _____
Others: _____ Phone #: _____ Relationship to Client: _____

Emergency Contact(s):

Name: _____ Phone #: _____Relationship to client: _____
Name: _____ Phone #: _____Relationship to client: _____

Clients Name: _____

Primary Care Physician:
Name: _____ Phone #: _____ Date of last physical: _____
Can Jackson Counseling Solutions LLC provide or obtain information from your PCP?
Yes No

Psychiatrist:
Name: _____ Phone #: _____ Date of last appt: _____
Can Jackson Counseling Solutions LLC provide or obtain information from your Psychiatrist? Yes No

As necessary, we will discuss signing a Release of Information for communication between Stacey Jackson, LICSW and your PCP and/or Psychiatrist. They will not be contacted without signed authorization.

Payment and Insurance Information:

Person Responsible for Payment (ie. self, parent): _____

Insurance Company: _____ Policy Number: _____
Group:_____

Full Name of Insured: _____ Birthday of Insured: _____

Your Relationship to Insured: self spouse child other

By Signed below, you authorize Jackson Counseling Solutions LLC to file insurance claims using the above provided information. If your insurance changes, it is your responsibility to inform us of the change in order to avoid additional out of pocket expenses. A copy of the front and back of your insurance card must be provided.

_____ _____
Signature of Client or Guardian Date

*Opt Out of use of Insurance: If you would prefer to not have claims submitted through your insurance, please let me know so an opt out form can be completed.

How did you find out about Jackson Counseling Solutions?_____

Jackson Counseling Solutions, LLC
Stacey Jackson, LICSW

Clients Name: _____

Please answer the following as detailed or as little as you feel comfortable. Feel free to write on the back of the page if necessary. If there is an area you do not wish to discuss, please indicate.

Presenting Problems? How long have you been experiencing this?

_____
_____
_____

Prior psychiatric symptoms and treatment:

_____
_____
_____

Prior Psychiatric testing and/or diagnosis:

_____
_____
_____

Trauma or Abuse History:

_____
_____
_____

Current Medications (please include name, dosage, and indication):

_____
_____
_____

Relevant Medical History:

_____
_____
_____

Jackson Counseling Solutions, LLC
Stacey Jackson, LICSW

Client Name: _____

Family Psychiatric/substance abuse History:

_____

_____

_____

Current or Prior Drug/Alcohol Abuse:

_____

_____

_____

Who is in your family? Relationship with them?

_____

_____

_____

Who lives in the home? Are there conflicts or stress? Safety concerns at home?

_____

_____

_____

How was your childhood, schooling, upbringing, etc?

_____

_____

_____

Education and Employment history and current status:

_____

_____

_____

Religious or Spiritual Beliefs:

_____

_____

Jackson Counseling Solutions, LLC
Stacey Jackson, LICSW

Name: _____

Current or Prior Legal History:

_____

_____

What do you feel are your strengths?

_____

_____

What do you feel are your weaknesses? Possible barriers to treatment?

_____

_____

Who do you consider is in your support system?

_____

_____

Any other Relevant information you would like to share:

_____

_____

_____

Jackson Counseling Solutions, LLC
Stacey Jackson, LICSW