ENHANCE LIFE COUNSELING, LLC

7570 W. 21st St. Suite D - Wichita, KS 67205

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Adult Intake Form

Name: _____
First Name Middle Initial Last

DOB: _____ Age: _____

Address: _____ Apt# _____

City, State, Zip: _____

Phone Numbers: _____ Home _____ Cell _____ Work

Email Address: _____

IN CASE OF EMERGENCY PLEASE IDENTIFY ONE PERSON YOU AUTHORIZE YOUR CLINICIAN TO CONTACT:

Name: _____ Phone Number: _____

Martial Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Other

Please list all persons (including yourself) currently living in your household.

	Name:	Relationship	DOB	Age	Occupation/Years of Education
1					
2					
3					
4					
5					

Describe your family, culture and religious connections: _____

_____

_____

Who referred you to us: _____

What problems bring you to seek treatment: _____

Is treatment Court Ordered: _____ Yes _____ No

Spirituality:

Would you describe your spiritual beliefs as producing: _____ Comfort _____ Stress _____ N/A

Are you an active participant in a religious community? _____ Yes _____ No _____ N/A

Would you like the counseling process to include:

Scripture Discussion: _____ Yes _____ No Prayer: _____ Yes _____ No

Substance Use: (Please mark each that apply with '1' current and '2' past)

_____ Tobacco _____ Alcohol _____ Non-Prescription Drugs _____ Other

Self/Family Mental Health History: (Please mark each that apply with '1' for self, '2'for immediate family 3' for extended family)

_____ Individual Therapy
_____ Marital Therapy
_____ Family Therapy
_____ Sex Therapy
_____ Domestic Violence
_____ Anger Management
_____ Group Therapy
_____ Grief
_____ Loss
_____ Anxiety
_____ Depression
_____ ADHD
_____ Sexual Abuse
_____ Physical Abuse
_____ Bipolar Disorder
_____ Eating Disorder
_____ Psychiatric Hospitalizations
_____ Schizophrenia
_____ Antisocial Behavior (history of violating the law)
_____ Drug Use
_____ Alcohol Use
_____ Other Substances
_____ Other Addictions

Currently Prescribed Medications and Prescribing Physician:

_____

_____

Current General Functioning: (Please mark each that apply)

_____ Cheerful/Happy mood most of the time
_____ Sad or tearful most of the time
_____ Feelings of hopelessness/ emptiness
_____ Withdrawn behaviors/Isolation
_____ Difficulty concentrating
_____ Under active/sluggish behavior
_____ Decrease in interests/activities
_____ Feelings of guilt
_____ Down most days
_____ Weight Loss
_____ Increased appetite
_____ Weight gain
_____ Suicidal Thoughts
_____ No Energy
_____ Overly fatigued during the day
_____ Poor self-care/poor hygiene
_____ Suicide attempts
_____ Intentional self-harm (i.e. cutting)
_____ Worry
_____ Poor memory
_____ Extreme ups and downs in moods
_____ Stress
_____ Panic
_____ Avoidant
_____ Takes more than an hour to fall asleep
_____ Irritability
_____ Anger
_____ Unable to sleep in own bed through the night
_____ Night waking for longer than 30 minutes
_____ Hard to wake up in the morning
_____ Fearless/Engaging in reckless activities
_____ Fearful of places, situations or people
_____ Fast/Rapid speech feel rested after 3-4 hours of sleep
_____ Exaggerated views of abilities
_____ Lying

_____ Threat to hurt someone with intent/plan

_____ Stealing

_____ Verbal threats to harm others

_____ Explosive outbursts

_____ Legal Problems

_____ Problems with school performance

_____ Inability to sustain attention

_____ Impulsivity

_____ Nightmares

_____ Sexual concerns

_____ Problems with relationships

_____ Divorce

_____ Martial Problems

_____ Shame

_____ Concerns with child care

_____ Intentional purging

_____ Binge eating

_____ Obesity

_____ Physical aggression

_____ Physical cruelty to animals

_____ Thoughts of harm to others

_____ Distinct periods of nonstop activity

_____ Extreme conflict with others

_____ Problems with work performance

_____ Easily distracted

_____ Compulsions

_____ Sleepwalking

_____ Excessive masturbation

_____ Jealousy

_____ Marital Affair

_____ Trust

_____ Crisis

_____ Disability

_____ Anorexia

_____ Body image

_____ Conflict with authority Figures

_____ Property damage

_____ Inability to remain seated

_____ Poor social skills

_____ Grandiosity-unrealistic sense of superiority

_____ Inability to complete tasks

_____ Overactive/hyperactive

_____ Denial

_____ Wetting accidents

_____ Pain during intercourse

_____ Blended family

_____ Family conflict

_____ Enabling

_____ Concerns with elder care

_____ Employment

_____ Hoarding Food

_____ Bulimia

_____ Self-esteem

AUTHORIZATION AND CONSENT

By signing below you are authorizing Enhance Life Counseling to provide you with mental health services. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Signature X _____ Date: _____

Billing Information: If billing information is not complete and accurate, we reserve the right to NOT schedule additional appointments until it is supplied.

Payment Options: _____ Insurance _____ Self-pay _____ Other

Primary Insurance Policy Information:

Primary insurance Company: _____

Insurance Member ID Number: _____ Insurance Group Number: _____

Effective Date: _____

Primary Insurance Insured Person Information:

Client's relationship to insured (i.e. self, spouse, child, other) _____

Insured Name: _____

Insured's Street Address: _____

Insured's City, State, Zip: _____

Insured's Phone Number: _____

Insured's Date of Birth: _____ Insured's Gender _____ Male Female

Insured's Employer: _____

By signing this agreement below you agree to and acknowledge each of the following conditions:

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit card.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Enhanced Life Counseling will notify you in writing.
4. You assume responsibility for any and all fee's rendered associated with services including documents preparation fees provided at Enhanced Life Counseling.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30 charge.
7. You are responsible for notifying Enhanced Life Counseling of any changes in name, address, phone number or insurance coverage.
8. By signing this agreement, you agree to allow Enhanced Life Counseling to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Enhanced Life Counseling shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name: _____ Date: _____

Signature X: _____