Client Intake Form- ADULT

Today's Date: **How did you hear about us?**

Personal Information

First Name:	**MI:**	**Last Name:**
Birthdate:	**Age:**	☐ **Male** ☐ **Female**
Address:	**City:**	**State:** **Zip:**

Contact Information

Mobile:	☐ **I give permission to leave a message at this number.** ☐ **I DO NOT give permission to leave a message at this number**
Email:	☐ **I give permission to be contacted by email**

What is your preferred method of contact? (mark only one): ☐ **Mobile Phone** ☐ **Email**

Employment

Employer:	**Work Phone:**
Employer address:	

Emergency Contact Information

Name:	**Relationship:**
Mobile:	

Others In the Home

Relationship Status: ☐ **Single** ☐ **Married** ☐ **Co-habitating** ☐ **Separated** ☐ **Divorced** ☐ **Other**	
Spouse/Partner:	**Children's Names/Ages:**

Insurance Information

Insurance Provider:	**Employer:**
Policy Number/Member ID:	**Group Number:**
Policy Holder's Name:	**DOB:** ☐ **Male** ☐ **Female**
Policy Holder's Address:	**Phone Number:**
Client's Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	
Employee Assistant Program Provider:	**Authorization:** **# of Visits:**

Agreements

Please initial next to each then sign below.

HIPAA AND YOUR PROTECTED HEALTH INFORMATION

_____ You have read the HIPAA and Protected Health Information agreement and agree to its term. You acknowledge you have received this notice of privacy practices.

INFORMATION DISCLOSURE AND INFORMED CONSENT FORM

_____ You have read and reviewed this informed consent. You understand and agree to all of the terms as they are written including fees, no-show fee and children as minors. In addition you have been offered a copy of this form for your own records.

CLIENT RIGHTS

_____ You have read, understand and accept my rights as a client of Kara Kang, LCPC regarding both privacy practices and the scope of services available.

Authorizations

AUTHORIZATION TO TREAT A MINOR CHILD

_____ You have read the authorization, agree to its concerns and hereby consent for Kara Kang, LCPC to provide services to the minor child listed below.

MANAGED CARE INSURANCE PLANS RELEASE OF INFORMATION

_____ You have read the information regarding the release of protected health information and authorize Kara Kang, LCPC to coordinate your care with your insurance plan and primary care physician.

Client Name (printed): _____ Date: _____

Client OR Parent/Guardian Signature: _____

Clinical History Form

Briefly describe the reason(s) you are seeking counseling:
About how long have you been concerned about this: ☐**1 month** ☐**2-3 months** ☐**6months** ☐**1 year** ☐**Other**

SYMPTOMS SCREENER

For the questions below, select one option for each question that best represents your answer.

OVER THE PAST TWO WEEKS, HAVE YOU:	**Not at all**	**1-2 days**	**3-5 days**	**Daily**
Experienced sadness, weepiness, or crying spells?	☐	☐	☐	☐
Felt hopeless, pessimistic or discouraged about the future?	☐	☐	☐	☐
Not been able to enjoy things?	☐	☐	☐	☐
Felt tired, slowed down or had no energy?	☐	☐	☐	☐
Lacked motivation or interest in doing things?	☐	☐	☐	☐
Had difficulty falling asleep or frequent waking/sleeping too much?	☐	☐	☐	☐
Had difficulty making decisions or concentrating?	☐	☐	☐	☐
Experienced decreased/decreased appetite?	☐	☐	☐	☐
Felt guilty or worthless?	☐	☐	☐	☐
Felt like you wanted to die, or wished you were dead?	☐	☐	☐	☐
Seriously considered or planned to end your own life?	☐	☐	☐	☐
Felt restless, worried, or nervous?	☐	☐	☐	☐
Had headaches, stomachaches or pain?	☐	☐	☐	☐
How much distress would you say these symptoms caused you?	☐ Mild	☐ Moderate	☐ Severe	

HISTORY OF RECREATIONAL DRUG USE

Amphetamines/Speed	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Barbiturates	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Heroin	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Narcotics (Vicodin, Oxy)	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Cocaine	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
LSD, Ecstasy, Bath Salts	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Cannabis/Marijuana	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Benzodiazepines	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
PCP	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:
Adderall (non-prescribed)	☐**Yes**	☐**No**	Age of First Use:	Age of last use:	Method:

In the past twelve months have you used drugs for anything other than medical reasons? ☐**Yes** ☐**No**
Have you ever experienced withdrawal symptoms when you stopped taking drugs? ☐**Yes** ☐**No**

HISTORY OF RECREATIONAL DRUG USE		
Do you regularly drink alcohol (including beer or wine?)	☐**Yes**	☐**No**
How often do you typically drink? ☐2x per month or less ☐Weekly ☐Daily		
How often do you typically drink? ☐2x per month or less ☐Weekly ☐Daily		
Has your drinking ever caused problems between you and family members or close relationships?	☐**Yes**	☐**No**
Have you tried to cut back or stop drinking but not been successful?	☐**Yes**	☐**No**
Have you drank alcohol and been hung over while working, going to school or taking care your children?	☐**Yes**	☐**No**
Have you missed or been late for work, school or other activities because you were drunk or hung over?	☐**Yes**	☐**No**
Have you ever been in trouble with the law because of drinking?	☐**Yes**	☐**No**
Have you ever experienced withdrawal symptoms when you stopped drinking?	☐**Yes**	☐**No**

SELF-HARM			
Have ever cut yourself or hurt yourself Intentionally?	☐**Yes**	☐**No**	**If yes describe:**

PSYCHIATRIC HISTORY

HAVE YOU USED COUNSELING SERVICES IN THE PAST? ☐**Yes** ☐**No**

Name of Counselor	**Primary Reason**	**Location**	**Outcome/Was it helpful?**
			☐**Yes** ☐**No**
			☐**Yes** ☐**No**

HAVE YOU HAD A PREVIOUS DIAGNOSIS OF:

☐**Anxiety** ☐**Depression** ☐**Panic** ☐**ADHD** ☐**OCD** ☐**Bipolar** ☐**Anorexia** ☐**Bulimia** ☐**PTSD** ☐**Alcoholism**

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐**Yes** ☐**No**

When/Dates	**Location**	**Purpose**	**Length of Stay**

HAVE YOU EVER ATTEMPTED SUICIDE? ☐Yes ☐No If Yes, then:		
Dates	**Method**	**Lethality (required medical intervention?)**

PSYCHIATRIC HISTORY

MOTHER	FATHER	SIBLINGS	EXTENDED FAMILY/ GRANDPARENTS
☐ADD/ADHD	☐ADD/ADHD	☐ADD/ADHD	☐ADD/ADHD
☐Alcohol Addiction	☐Alcohol Addiction	☐Alcohol Addiction	☐Alcohol Addiction
☐Substance Abuse	☐Substance Abuse	☐Substance Abuse	☐Substance Abuse
☐Anxiety	☐Anxiety	☐Anxiety	☐Anxiety
☐OCD	☐OCD	☐OCD	☐OCD
☐Depression	☐Depression	☐Depression	☐Depression
☐Bipolar	☐Bipolar	☐Bipolar	☐Bipolar
☐Eating Disorder	☐Eating Disorder	☐Eating Disorder	☐Eating Disorder
☐PTSD	☐PTSD	☐PTSD	☐PTSD
☐Schizophrenia	☐Schizophrenia	☐Schizophrenia	☐Schizophrenia
☐Anger Management	☐Anger Management	☐Anger Management	☐Anger Management
☐Personality Disorder	☐Personality Disorder	☐Personality Disorder	☐Personality Disorder
☐Attempted Suicide	☐Attempted Suicide	☐Attempted Suicide	☐Attempted Suicide
☐Completed Suicide	☐Completed Suicide	☐Completed Suicide	☐Completed Suicide
☐Other:	☐Other:	☐Other:	☐Other:

GENERAL SOCIAL HISTORY

WHICH BEST DESCRIBES YOUR SOCIAL SITUATION?

☐Supportive social network ☐Close to family of origin ☐Distant from family of origin ☐Feeling lonely/isolated
☐No friends ☐Conflict with family members

CURRENT OCCUPATIONAL STATUS

☐Employed Full-time ☐Employed Part-Time ☐Unemployed/Longest Period of Unemployment:
☐Part-time student ☐Full-time Student ☐Disability ☐Other:

HISTORY OF INTIMATE RELATIONSHIPS

☐Married 1x ☐Significant relationships/Never married ☐Single, never married
☐Divorced/not remarried ☐Divorced/Remarried ☐Other:

SATISFACTION WITH CURRENT INTIMATE RELATIONSHIP

☐Satisfied ☐Somewhat unsatisfied ☐Unsatisfied ☐Other:

PERSONAL RESOURCES

DESCRIBE YOUR PERSONAL STRENGTHS

WHAT WOULD YOU LIKE TO SEE IMPROVE AS A RESULT OF COUNSELING (GENERAL GOALS)?

WOULD INCLUDING SPIRITUALITY IN YOUR COUNSELING BE BENEFICIAL? ☐Yes ☐No ☐Not sure

Describe religious background and/or preference?

MEDICAL HISTORY

PRIMARY CARE

Primary Care Physician:
Office Address:
Phone Number:

MEDICAL HISTORY

Current/Past Medical Conditions:

☐**Heart Disease**	☐**Anemia**	☐**Headaches/ Migraines**	☐**Stroke**	☐**Arthritis**	☐**Hepatitis**
☐**Shortness of Breath**	☐**Asthma**	☐**Diabetes**	☐**Kidney Problems**	☐**Cancer**	☐**Menstrual Problems**
☐**High Cholesterol**	☐**Hormone Imbalance**	☐**Dementia**	☐**Liver Problems**	☐**Thyroid**	☐**Sleep Apnea**
☐**High Blood Pressure**	☐**Seizure/Epilepsy**	☐**Head Trauma**	☐**Ulcers**	☐**Fibromyalgia**	☐**Smoke**

Other:

Do you have allergies: ☐YES ☐NO List:

Are you currently taking medication: ☐YES ☐NO

Name of Medication	Dosage	Frequency	Purpose

FAMILY HISTORY OF ILLNESS/DISEASE

☐**None**	☐**Cancer**	☐**Asthma**	☐**Heart Disease**
☐**Diabetes**	☐**High Blood Pressure**	☐**Thyroid**	☐**Epilepsy**
☐**Dementia/Alzheimer's**	☐**Hormone Imbalance**	☐**Migraines**	☐**Other**

CURRENT PSYCHIATRIC CARE

☐Psychiatrist ☐Developmental Therapy ☐Case Management ☐Service Coordination ☐CBRS ☐Other:

Name of provider/s	Location	Phone

CURRENT PSYCHIATRIC MEDICATION			
Name of Medication	**Dosage**	**Frequency**	**Purpose**