Jacy Hargrave, CMHC Intake Form

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Adult Intake Form

Referred by: _____ (Person and/or Agency)

Client Name: _____(First, Middle Initial, & Last)

Home Address: _____

City, State, & Zip:_____

Date of Birth: _____ Social Security Number (SSN)_____

Ethnicity: _____ Sexual Orientation: _____

Culture/Ethnicity:_____ Religious: ☐ Not ☐ Little ☐ Moderate ☐ Much

Preferred Pronouns:_____ Cell Phone#: _____

Email: _____

Preferred Contact Method (check preferred) : _____ Email _____ Phone _____Text message

Has the client being seen today been a patient here before? (Please check) ☐ Yes ☐ No

Place of Employment: _____ Job Title: _____

Employment Address: _____

Work Phone #: _____ May we contact you at work? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse/Partner: _____ Children: ☐ Yes ☐ No

Amount of Children & Ages: _____

Mental Health History:

Are you currently experiencing suicidal thoughts?

☐ No ☐ Yes (please explain):

_____

_____

Substance Use (alcohol, drugs, etc.): ☐ None ☐ Occasional ☐ Regular ☐ Past Use

If applicable, please describe:

_____

_____

Previous Diagnoses (if any):

_____

_____

Current Medications (if any):

_____

_____

Allergies or Medical Conditions:

_____

_____

History of Hospitalizations (psychiatric):

_____

_____

Past Therapy or Counseling Experiences (when, where, and reason):

_____

_____

Family Mental Health History (if known):

_____

_____

Treatment Goals:

Primary Reason for Seeking Services:

_____

_____

What are the main concerns you would like to address?

_____

_____

What goals would you like to achieve through counseling?

_____

_____

Minor Client Information

Referred by: _____ (Person and/or Agency)

Client Name: _____ Age: _____

School: _____ Grade: _____

Major (if applicable): _____ Interests/Hobbies: _____

Primary Care Physician: _____

Parent/Guardian Name: _____Phone #: _____

Relationship to Minor: _____Parent/Guardian Email: _____

Custody Arrangement (if applicable): _____

Emergency Contact (if different from guardian): Name: _____

Phone #: _____ Email: _____

Any Behavioral or Academic Concerns:

_____

_____

Current Medications (if any):

_____

Allergies or Medical Conditions:

_____

Financial Responsibility

Responsible Party for Payment will be: ☐ Client/Self ☐ Mother ☐ Father Other _____

Responsible Party Contact Information; Name: _____

Home Address: _____

Date of Birth: _____ SSN: _____

Cell Phone #: _____ Home Phone #: _____

Insurance(s) Information

*You may skip this section if you submitted a copy of your insurance card(s).

Primary Insurance Company: _____

Employer: _____

Policy Holder Name: _____SSN: _____ DOB: _____

Address: _____

Group ID Number: _____ Group Number: _____

Policy Number: _____

Pre-Authorization Number: _____Number of Sessions: _____

Secondary Insurance Company: _____

Employer: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

Address: _____

Group ID Number: _____ Group Number: _____

Policy Number: _____

Supervisor Signature: _____ Date:_____