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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: _____ Cell Phone # _____
Email: _____
Preferred Contact Method: ☐ Email ☐ Phone ☐ Text message

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

The purpose for this evaluation (check all that apply):
□ Educational, e.g., IEP/504 plan
□ Medication management
□ Self-aware/self-improvement
□ Career choice
□ Legal/forensic, please specify: _____
□ Other, please specify_____

What diagnoses are you speculating or wanting to confirm (check all that apply):
□ Autism □ ADHD □ Learning disabilities □ Developmental delays □ Behavioral disorders
□ Depression □ Bipolar □Anxiety □ OCD □ PTSD □ Personality Disorders □ Giftedness
□ Other, please specify: _____

When did the problem start? _____
How long has this problem been going on? _____
How often does the problem occur? _____
How does the problem affect your daily life/functioning? _____
_____
_____
What steps have you taken so far to resolve this problem? What have been the results of your attempts to resolve this issue?
_____
_____

Family History:

Born in: _____ (city & state); Currently living in: _____ (city& state) in a (please circle): house, apartment, trailer, duplex, shelter, homeless, other_____ (please specify). Who are currently living with you (how they relate to you): _____

How many Siblings_____ /half-siblings_____ /step-siblings_____ and their age(s)_____

On **mom's** side of the family has the following confirmed diagnoses or problems (please circle): depression, anxiety, bipolar, schizophrenia, ADHD, learning disorders, autism, substance abuse, alcoholism, criminal conduct, domestic violence, and abuse.
On **dad's** side of the family has the following confirmed diagnoses or problems (please circle): depression, anxiety, bipolar, schizophrenia, ADHD, learning disorders, autism, substance abuse, alcoholism, criminal conduct, domestic violence, and abuse.

Developmental History:

Have you met the developmental milestones early, normal, or delayed?

	early	normal	delayed
Walking	_____	_____	_____
Talking	_____	_____	_____
Potty Training	_____	_____	_____

Have you ever received speech therapy? Yes____ No_____ If "yes", please indicated the time frame (which grade/year to which grade/year): _____

Were you ever abused as a child or an adult? Yes ___ No ___
If "Yes", please specify from age (or year) _____ to age (year)_____ and Type of abuse: Verbal, physical, sexual, emotional (circle) by _____ (stranger, family friend, neighbor, family member, etc.) If family member, how does the family member relate to you?_____
Was there a DCFS/DHS involvement? Yes ___ No ___ If yes, was the case founded? Yes ___ No ___

Medical, Mental, Behavioral, and Physical Diagnoses:

Diagnoses received	When (month/year)	Which agency/organization	Professional (Primary care, Psychiatrist, Counselor, etc.)

Psychiatric Hospitalization History:

When (month/year):_____ Which Hospital: _____ How long the say: _____
Reason for hospitalization: □ suicidal thoughts □ suicidal attempt □overdose on_____
□ homicidal ideation □ psychosis, please explain: _____
_____
_____
When (month/year):_____ Which Hospital: _____ How long the say: _____

Reason for hospitalization: □ suicidal thoughts □ suicidal attempt □overdose on_____
□ homicidal ideation □ psychosis, please explain: _____
_____
_____

History of Counseling/Therapy (if applicable):

From _____ to _____ (year or age), received counseling for _____
From _____ to _____ (year or age), received counseling for _____
From _____ to _____ (year or age), received counseling for _____

History of Occupational Therapy and Physical Therapy (if applicable):

From ____(weeks/months) in _____ (year or age), received _____ (OT/PT) for _____
From ____(weeks/months) in _____ (year or age), received _____ (OT/PT) for _____

Medication(s):

Medicine Name	Dosage (mg)	When initially prescribed	Continue or Discontinued?
			C D
			C D
			C D
			C D

Drug & Alcohol History:

Drug/alcohol Name	1st time use age	Frequency	Last time use date or age	How much (last time use)

Educational History

Highest level of education (e.g., elementary, middle, high school, or college) _____
City & State: _____ GED (if applicable) _____
If college, Degree:_____; Major: _____;
GPA upon graduation: _____

Any classes are/were in the IEP program (Special Ed)? Yes ____ No____

If “yes”, what is/was the time frame for the IEP? From _____th grade to _____th grade? which classes involved? _____
Any classes are/were in the 504 program? Yes ____ No____
If “yes”, what is/was the time frame for the 504 plan? From _____th grade to _____th grade? which classes involved? _____

Do/did you struggle with the following when you were in school:

- peer relationship difficulties ___
- authority problems_____
- academic problems _____

Please explain if any of the above was checked: _____
_____

Employment History

Are you currently employed? Yes _____ No_____

Most recent/current employment place: _____ Job title: _____
Full-time or part-time? _____How long have you worked here? _____
Work-Related Difficulties, if any: _____
_____
Reasons for quitting/termination: _____
_____

Previous employment _____ Position/title: _____
Full-time or part-time? _____How long did you work there? _____
Work-Related Difficulties, if any: _____
_____
Reasons for quitting/termination: _____
_____

The longest employment you’ve held in your life was working for _____
(company name) for _____ years. How many times you were fired from a job in your life: _____. Please list the reason(s) for being terminated (if applicable): _____
_____

Marriage(s) & Children:

You are currently: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed
Number(s) of marriage: _____

The 1st marriage lasts/lasted from: _____to ____ (year). Reason for divorced (if applicable): _____

_____

The 2nd marriage lasts/lasted from: _____to ____ (year). Reason for divorced (if applicable): _____

_____

Child (ren) Age(s) Daughter/Son _____years old
Daughter/Son _____years old
Daughter/Son _____years old
Daughter/Son _____years old

Legal/Criminal History

Please list the year(s) and charges(s) you received in your life, if you have any.

Year	Charges	Jail Term and/or fines?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently on probation? ☐ Yes ☐ No If "yes", when will your probation end? _____

Military Services (if applicable):

Branch of service_____ Time frame of service_____ Location_____

Discharge status_____

Were you diagnosed with PTSD as a vet? Yes___ No__ If "yes", which year? _____

Religious Involvement

Religious belief: _____ Going to church? ☐ Yes ☐ No

If "Yes", how often? _____

Hobbies & Activities

Please list a few things the client does for fun (such as bike riding, playing video games, etc.):

_____

_____

_____

Financial Responsibility

The responsible party for payment will be (please circle):

Client self Mother Father Other (please specify): _____

Responsible party contact information (if different from above):

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

Home Address: _____
Date of Birth: _____ SSN: _____
Cell Phone # _____ Home Phone: _____
Place of Employment: _____ Job Title: _____
Employment Address: _____
Work Phone # _____

Insurance(s) Information
[*You may *skip* this section if you submitted a copy of your insurance card(s). Please sign at bottom.]

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: _____

☐ I hereby authorize my insurance company to make payment directly **to <u>Dr. Jackie Jiang & Associates, LLC for</u>** professional services rendered and I shall be personally responsible for any unpaid balance to the group practice.

☐ I do **not** wish my insurance to be billed and I will pay for services rendered. I understand that a service charge of 1.5% (18% per year) may be added to any outstanding co-pay or deductible balance more than 30 days old.

Client Signature: _____ Date: _____