

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
What problem, difficulty, or concern do you need assistance with?

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: _____
Sibling/half-sibling/step-sibling _____ Age(s) _____

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

Marriage(s) & Children: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number(s) of marriage: _____ Marriage lasts/lasted from: _____ to _____ (year)

Child (ren) Name(s) and Age(s) _____

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

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.)

Medical, Mental, Behavioral, and Physical Diagnoses:

Diagnoses received

When received the diagnoses (month/year)

Primary Care Physician: _____ at _____

Psychiatric Hospitalization:

Month/Year _____ Hospitalization reasons: _____ Length of stay _____

Month/Year _____ Hospitalization reasons: _____ Length of stay _____

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	1 st time use age	Frequency	Last time use date or age	How much (last time use)

Educational History

Name of most current school (e.g., elementary, middle, high school, or college) _____

Grade/Degree: _____ GED (if applicable) _____

If college, Degree: _____; Major: _____

Any classes are/were in the IEP program (Special Ed)? Yes ___ No___

If "yes", which classes _____

If "yes", what is/was the time frame have you had an IEP? From ___th grade to ___th grade.

Were you in the 504 program? Yes ___ No___

If "yes", which classes _____

If "yes", what is/was the time frame have you had an IEP? From ___th grade to ___th grade.

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 _____ Position/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 have you worked here? _____

Work-Related Difficulties, if any: _____

Reasons for quitting/termination: _____

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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 **Dr. Jackie Jiang Counseling & Evaluation, LLC** for professional services rendered and I shall be personally responsible for any unpaid balance to the clinician.

☐ 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.

Signature: _____

Date: _____