Dr. Jackie Jiang & Associates
Phone: 309-944-7833 Fax: 309-403-0554

Intake Form

Referred by _____ (Person and/or Agency)
Client Name: _____ (First, Middle Initial, & Last)
Home Address: _____
Date of Birth: _____ Social Security Number (SSN): _____
Ethnicity: _____ Cell Phone # _____
Leave a message at your answering machine? ☐Yes ☐No
Leave a message with a family member? ☐Yes ☐No

Name of Spouse/Partner/Parent (please circle one; if applicable): _____
Home Address (if different): _____
Cell Phone # _____ Home Phone # (if different) _____
Place of Employment_____ Job Title _____

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: _____

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 ☐Seperated ☐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	1st 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) _____

Grade: _____ GED (if applicable) _____

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: _____
_____

College (if applicable) : _____
Degree:_____; Major _____

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? _____

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 Counseling & Evaluation, LLC</u>** 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: _____