Intake form for Liv Carrow, LCSW/LISW

Dr. Jackie Jiang & Associates

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Adult Intake Form

Client Name: _____

Home Address: _____

City, State, & Zip: _____

Date of Birth:_____Cell Phone # _____

Email:_____

Preferred Contact: Email Phone Text

Nickname or preferred name: _____

Preferred pronouns:_____Gender identity:_____

Cultural, racial or ethnic identities:_____

Have you been seen here before? _____

Have you been a client of Liv's before?_____

When/where?_____

What has brought you to seek therapy now? _____

_____

_____

When did the problem start?_____

How long has this problem been going on? _____

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:_____Currently living in:_____

Living with:_____

Siblings___/half-siblings___/step-siblings___ and their age(s)_____

Marital/Relationship status:_____

Are there children in the home where you live?_____

Names/Ages/Relationship:_____

_____

Who are your primary current supports?_____

Family religious beliefs:_____

Family cultural or ethnic identity:_____

Parents professions and level of education:_____

_____

Medical, Mental, Behavioral, and Physical Diagnoses:

Diagnoses received	When (month/year)	Which agency/organization	Name of Professional that diagnosed you

Do you have a history of traumatic brain injury, concussion, overdose, strangulation, or contact sports?_____

_____

Psychiatric Hospitalization or inpatient treatment:

When (month/year):_____Length of stay:_____

Which Hospital:_____

Reason for stay:_____

When (month/year):_____Length of stay:_____

Which Hospital:_____

Reason for stay:_____

When (month/year):_____Length of stay:_____

Which Hospital:_____

Reason for stay:_____

History of Counseling/Therapy (if applicable):

What has been helpful?_____

_____

_____

What wasn't?_____

_____

_____

Are you currently in acute pain, discomfort, or distress?_____

History of chronic illness?_____

Have you had any thoughts of hurting yourself or not being alive in the past:

____Day ____Week ____Month ____Year ____Lifetime

Do you have a history of self-harming?_____

Have you ever been treated for or diagnosed with an eating disorder?_____

_____

Do you have any current systems involvement?

DHS/DCFS _____ Legal Suit_____

Probation/Parole _____ Court_____

Are you mandated to attend therapy?_____

Medication(s):

Current Medications	Dosages	Prescriber	Duration of Treatment

Do you take hormones for birth control, HRT or gender affirming therapy? _____

Type	Duration	Dose

Do you utilize any complimentary medicine or healing practices?_____

_____

_____

Drug & Alcohol History:

Drug/Alcohol Name	1st time use age	Frequency	Last Use Date/Age	Most Recent Use Quantity

History of overdose or poisoning?_____

History of withdrawal complications, or required medical detox?_____

_____

Other concerns or history of addictive or compulsive behaviors? Please circle:

Sex, Gambling, Gaming, Spending, Shopping, Collecting, Porn, Online Romance,

Skin Picking, Hair Pulling, Sports Betting, Unsafe Behaviors

Other:_____

Employment History

Are you currently employed?_____ Where/doing what?_____

What is your profession or job title?_____

How long have you worked here?_____

Work-Related Difficulties, if any:_____

_____

Other employment information relevant to your mental health:_____

_____

Educational history/student status:_____

Legal History

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

_____

_____

_____

Have you ever been under guardianship or committed to care?_____

_____

Are you able to come and go freely from your home and workplace?_____

_____

Does anyone in your life make you feel unsafe, or make you do things you don't want to do?_____

_____

_____

Has anyone ever taken your passport/ID, restricted your access to a phone or the internet?_____

Does anyone else have access to your money or bank account, or has anyone taken money from you without your permission?_____

Military Services (if applicable):

Branch of service_____Time frame of service_____

Did you deploy or were you in active combat?____ When/where?_____

_____

Are you receiving disability & are you service connected with the VA or Vet Center?____

_____

Spirituality/Religion

Religious or spiritual beliefs/practices:_____

Religion of family of origin:_____

Current involvement or practice:_____

Hobbies & Activities

What do you do for fun, enjoy, or look forward to?_____

_____

Are there things you would like to resume doing, or do more of?_____What are they?

_____

_____

Financial Responsibility

The responsible party for payment will be: (Circle One)

Client self Mother Father Other (please specify):_____

Responsible party contact information (if different from client self):

Name:_____Date of Birth:_____

Home Address:_____

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 the bottom.]

Primary Insurance Company:_____

Employer:_____

Policy Holder Name and Relation:_____

SSN:_____DOB:_____

Address:_____

Policy ID Number:_____Group Number:_____

Secondary Insurance Company:_____

Employer:_____

Policy Holder Name and Relation:_____

SSN:_____DOB:_____

Address:_____

Policy ID Number:_____Group 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 agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document.

☐ 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:_____