**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? [ ] 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: Choose an item.

(please specify if live in “other”:      )

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: [ ] 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: [ ] 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?

Walking Choose an item. Talking : Choose an item. Potty Training: Choose an item.

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: Choose an item. By [ ] stranger(s), [ ] family friend, [ ] neighbor, [ ] family member. 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  |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |

**Psychiatric Hospitalization:**

When (month/year):       Which Hospital:       Length of stay:

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):**

      (year or age), for how long       received Choose an item. for

      (year or age), for how long       received Choose an item. for

**Medication(s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine Name | Dosage (mg) | When initially prescribed (month/year) | Continue or Discontinued? |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |
|       |       |       | Choose an item. |

**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): Choose an item.

If college, Degree: Choose an item.; 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:       Position/title:

[ ] Full-time or [ ] part-time? How long have you worked here?

Work-Related Difficulties, if any:

Reasons for quitting/termination:

Previous employment place:       Position/title:

[ ] Full-time or [ ] part-time? How long have you worked here?

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 or son \_\_\_\_\_\_\_\_\_\_\_\_years old

 daughter or son \_\_\_\_\_\_\_\_\_\_\_\_years old

 daughter or son \_\_\_\_\_\_\_\_\_\_\_\_years old

 daughter or 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: [ ] Client self [ ] Mother [ ] Father [ ] Other (please specify):

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

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:

Policy ID Number:       Group Number:

Secondary Insurance Company:

Employer:

Policy Holder Name:       SSN:       DOB:

Address:

Policy ID Number:       Group Number:

[ ] I hereby authorize my insurance company to make payment directly **to Dr. Jackie Jiang & Associates, LLC for** 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: