**Client Intake Form- ADULT**

**Today’s Date: How did you hear about us?**

**Personal Information**

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| **First Name: MI:** | **Last Name:** |
| **Birthdate: Age:** | **☐ Male ☐ Female** |
| **Address: City: State: Zip:** |

**Contact Information**

|  |  |
| --- | --- |
| **Mobile:** | **☐ I give permission to leave a message at this number.****☐ I DO NOT give permission to leave a message at this number** |
| **Email:**  | **☐ I give permission to be contacted by email** |

**What is your preferred method of contact? (mark only one): ☐ Mobile Phone ☐ Email**

**Employment**

|  |  |
| --- | --- |
| **Employer:** | **Work Phone:** |
| **Employer address:**  |

**Emergency Contact Information**

|  |  |
| --- | --- |
| **Name:** | **Relationship:** |
| **Mobile:** |

**Others In the Home**

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| **Relationship Status: ☐Single ☐Married ☐Co-habitating ☐Separated ☐Divorced ☐Other** |
| **Spouse/Partner:** | **Children’s Names/Ages:** |

**Insurance Information**

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| **Insurance Provider:**  | **Employer:** |
| **Policy Number/Member ID:** | **Group Number:** |
| **Policy Holder’s Name:** | **DOB: ☐ Male ☐ Female** |
| **Policy Holder’s Address:** | **Phone Number:** |
| **Client’s Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other** |
| **Employee Assistant Program Provider:**  | **Authorization: # of Visits:** |

**Agreements**

*Please initial next to each then sign below.*

**HIPAA AND YOUR PROTECTED HEALTH INFORMATION**

\_\_\_\_\_\_ You have read the HIPAA and Protected Health Information agreement and agree to its term.

 You acknowledge you have received this notice of privacy practices.

**INFORMATION DISCLOSURE AND INFORMED CONSENT FORM**

\_\_\_\_\_\_ You have read and reviewed this informed consent. You understand and agree to all of the terms

 as they are written including fees, no-show fee and children as minors. In addition you have been

 offered a copy of this form for your own records.

**CLIENT RIGHTS**

\_\_\_\_\_\_ You have read, understand and accept my rights as a client of Alice Vandecaveye, LCSW regarding

 both privacy practices and the scope of services available.

**Authorizations**

**AUTHORIZATION TO TREAT A MINOR CHILD**

\_\_\_\_\_\_ You have read the authorization, agree to its concerns and hereby consent for Alice Vandecaveye,

 LCSW to provide services to the minor child listed below.

**MANAGED CARE INSURANCE PLANS RELEASE OF INFORMATION**

\_\_\_\_\_\_ You have read the information regarding the release of protected health information and

 authorize Alice Vandecaveye, LCSW to coordinate your care with your insurance plan and primary

 care physician.

Client Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client OR Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical History Form**

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| **Briefly describe the reason(s) you are seeking counseling:** |
|  |
| About how long have you been concerned about this: **☐1 month ☐2-3 months ☐6months ☐1 year ☐Other** |

**SYMPTOMS SCREENER**

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| For the questions below, select one option for each question that best represents your answer.  |
|  **OVER THE PAST TWO WEEKS, HAVE YOU:** |  **Not at all** |  **1-2 days** |  **3-5 days** |  **Daily** |
| Experienced sadness, weepiness, or crying spells? |  **☐** |  **☐** |  **☐** |  **☐** |
| Felt hopeless, pessimistic or discouraged about the future? |  **☐** |  **☐** |  **☐** |  **☐** |
| Not been able to enjoy things?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Felt tired, slowed down or had no energy? |  **☐** |  **☐** |  **☐** |  **☐** |
| Lacked motivation or interest in doing things?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Had difficulty falling asleep or frequent waking/sleeping too much?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Had difficulty making decisions or concentrating? |  **☐** |  **☐** |  **☐** |  **☐** |
| Experienced decreased/decreased appetite? |  **☐** |  **☐** |  **☐** |  **☐** |
| Felt guilty or worthless? |  **☐** |  **☐** |  **☐** |  **☐** |
| Felt like you wanted to die, or wished you were dead?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Seriously considered or planned to end your own life?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Felt restless, worried, or nervous?  |  **☐** |  **☐** |  **☐** |  **☐** |
| Had headaches, stomachaches or pain?  |  **☐** |  **☐** |  **☐** |  **☐** |
| How much distress would you say these symptoms caused you? ☐ Mild ☐ Moderate ☐ Severe |

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| **HISTORY OF RECREATIONAL DRUG USE** |
| Amphetamines/Speed |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Barbiturates |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Heroin |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Narcotics (Vicodin, Oxy) |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Cocaine |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| LSD, Ecstasy, Bath Salts |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Cannabis/Marijuana |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Benzodiazepines |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| PCP |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |
| Adderall (non-prescribed) |  **☐Yes** |  **☐No** | Age of First Use: | Age of last use: | Method: |

In the past twelve months have you used drugs for anything other than medical reasons? **☐Yes ☐No**

Have you ever experienced withdrawal symptoms when you stopped taking drugs? **☐Yes ☐No**

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| **HISTORY OF RECREATIONAL DRUG USE** |
| Do you regularly drink alcohol (including beer or wine?) |  **☐Yes**  |  **☐No** |
| How often do you typically drink? **☐**2x per month or less **☐**Weekly **☐**Daily |
| How often do you typically drink? **☐**2x per month or less **☐**Weekly **☐**Daily |
| Has your drinking ever caused problems between you and family members or close relationships? |  **☐Yes**  |  **☐No** |
| Have you tried to cut back or stop drinking but not been successful?  |  **☐Yes**  |  **☐No** |
| Have you drank alcohol and been hung over while working, going to school or taking care your children? |  **☐Yes**  |  **☐No** |
| Have you missed or been late for work, school or other activities because you were drunkor hung over?  |  **☐Yes**  |  **☐No** |
| Have you ever been in trouble with the law because of drinking?  |  **☐Yes**  |  **☐No** |
| Have you ever experienced withdrawal symptoms when you stopped drinking?  |  **☐Yes**  |  **☐No** |

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| **SELF-HARM** |
| Have ever cut yourself or hurt yourself Intentionally? |  **☐Yes ☐No** | **If yes describe:**  |

**PSYCHIATRIC HISTORY**

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| **HAVE YOU USED COUNSELING SERVICES IN THE PAST? ☐Yes ☐No** |
|  **Name of Counselor** | **Primary Reason** | **Location** | **Outcome/Was it helpful?** |
|  |  |  |  **☐Yes ☐No** |
|  |  |  |  **☐Yes ☐No** |
| **HAVE YOU HAD A PREVIOUS DIAGNOSIS OF:****☐Anxiety ☐Depression ☐Panic ☐ADHD ☐OCD ☐Bipolar ☐Anorexia ☐Bulimia ☐PTSD ☐Alcoholism**  |
| **HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐Yes ☐No** |
|  **When/Dates** | **Location** | **Purpose** | **Length of Stay** |
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| **HAVE YOU EVER ATTEMPTED SUICIDE? ☐Yes ☐No If Yes, then:** |
| **Dates** | **Method** | **Lethality (required medical intervention?)** |
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| **PSYCHIATRIC HISTORY** |
| **MOTHER** | **FATHER** | **SIBLINGS** | **EXTENDED FAMILY/****GRANDPARENTS** |
| **☐ADD/ADHD** | **☐ADD/ADHD** | **☐ADD/ADHD** | **☐ADD/ADHD** |
| **☐Alcohol Addiction** | **☐Alcohol Addiction** | **☐Alcohol Addiction** | **☐Alcohol Addiction** |
| **☐Substance Abuse** | **☐Substance Abuse** | **☐Substance Abuse** | **☐Substance Abuse** |
| **☐Anxiety** | **☐Anxiety** | **☐Anxiety** | **☐Anxiety** |
| **☐OCD** | **☐OCD** | **☐OCD** | **☐OCD** |
| **☐Depression** | **☐Depression** | **☐Depression** | **☐Depression** |
| **☐Bipolar** | **☐Bipolar** | **☐Bipolar** | **☐Bipolar** |
| **☐Eating Disorder** | **☐Eating Disorder** | **☐Eating Disorder** | **☐Eating Disorder** |
| **☐PTSD** | **☐PTSD** | **☐PTSD** | **☐PTSD** |
| **☐Schizophrenia** | **☐Schizophrenia** | **☐Schizophrenia** | **☐Schizophrenia** |
| **☐Anger Management** | **☐Anger Management** | **☐Anger Management** | **☐Anger Management** |
| **☐Personality Disorder** | **☐Personality Disorder** | **☐Personality Disorder** | **☐Personality Disorder** |
| **☐Attempted Suicide** | **☐Attempted Suicide** | **☐Attempted Suicide** | **☐Attempted Suicide** |
| **☐Completed Suicide** | **☐Completed Suicide** | **☐Completed Suicide** | **☐Completed Suicide** |
| **☐Other:** | **☐Other:** | **☐Other:** | **☐Other:** |

**GENERAL SOCIAL HISTORY**

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| **WHICH BEST DESCRIBES YOUR SOCIAL SITUATION?**  |
| **☐Supportive social network ☐Close to family of origin ☐Distant from family of origin ☐Feeling lonely/isolated ☐No friends ☐Conflict with family members**  |
| **CURRENT OCCUPATIONAL STATUS**  |
| **☐Employed Full-time ☐Employed Part-Time ☐Unemployed/Longest Period of Unemployment:****☐Part-time student ☐Full-time Student ☐Disability ☐Other:**  |
| **HISTORY OF INTIMATE RELATIONSHIPS**  |
| **☐Married 1x ☐Significant relationships/Never married ☐Single, never married****☐Divorced/not remarried ☐Divorced/Remarried ☐Other:**  |
| **SATISFACTION WITH CURRENT INTIMATE RELATIONSHIP**  |
| **☐Satisfied ☐Somewhat unsatisfied ☐Unsatisfied ☐Other:**  |

**PERSONAL RESOURCES**

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| **DESCRIBE YOUR PERSONAL STRENGTHS** |
| **WHAT WOULD YOU LIKE TO SEE IMPROVE AS A RESULT OF COUNSELING (GENERAL GOALS)?**  |
| **WOULD INCLUDING SPIRITUALITY IN YOUR COUNSELING BE BENEFICIAL? ☐Yes ☐No ☐Not sure** |
| Describe religious background and/or preference? |

**MEDICAL HISTORY**

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| **PRIMARY CARE** |
| Primary Care Physician:Office Address:Phone Number: |
| **MEDICAL HISTORY** |
| Current/Past Medical Conditions: |
| **☐Heart Disease** | **☐Anemia** | **☐Headaches/** **Migraines** | **☐Stroke** | **☐Arthritis** | **☐Hepatitis** |
| **☐Shortness of**  **Breath** | **☐Asthma** | **☐Diabetes** | **☐Kidney Problems** | **☐Cancer** | **☐Menstrual**  **Problems** |
| **☐High Cholesterol** | **☐Hormone**  **Imbalance** | **☐Dementia** | **☐Liver Problems** | **☐Thyroid** | **☐Sleep Apnea** |
| **☐High Blood** **Pressure** | **☐Seizure/Epilepsy** | **☐Head Trauma** | **☐Ulcers** | **☐Fibromyalgia** | **☐Smoke** |
| **Other:** |
| **Do you have allergies: ☐YES ☐NO List:** |
| **Are you currently taking medication: ☐YES ☐NO**  |
| **Name of Medication** | **Dosage** | **Frequency** | **Purpose** |
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| **FAMILY HISTORY OF ILLNESS/DISEASE** |
| **☐None** | **☐Cancer** | **☐Asthma** | **☐Heart Disease** |
| **☐Diabetes** | **☐High Blood Pressure** | **☐Thyroid** | **☐Epilepsy** |
| **☐Dementia/Alzheimer’s** | **☐Hormone Imbalance** | **☐Migraines** | **☐Other** |
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| **CURRENT PSYCHIATRIC CARE** |
| **☐Psychiatrist** **☐Developmental Therapy ☐Case Management** **☐Service Coordination ☐CBRS ☐Other:** |
| **Name of provider/s** | **Location** | **Phone** |
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| **CURRENT PSYCHIATRIC MEDICATION** |
| **Name of Medication** | **Dosage** | **Frequency** | **Purpose** |
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