Today's Date: _____

Adult Intake Form

Client Information

Name (first and last): _____Date of Birth: _____

Email address: _____Gender (M/F): _____

Address: _____

Best phone #: _____May I leave a message? ***Yes*** ***No***

Who I am authorized to communicate with (besides you): _____

Occupation: _____Employer/School: _____

Relationship Status: _____Race/Ethnicity: _____

Spiritual Beliefs: _____

Strengths: _____

Hobbies: _____

Name/Address of financially responsible party, if other than the client: _____

_____

Primary Concerns

Main reason for seeking counseling at this time:

_____

_____

_____

_____

_____

_____

_____

_____

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Medical Care

Clinic Name: _____

Doctor's Name: _____

Phone: _____

Address: _____

May I get a release of information in order to coordinate care with your doctor? ***Yes*** ***No***

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? ***Yes*** ***No***

If applicable, which type of treatment: ***Inpatient*** ***Outpatient*** ***Both***

If you have received some form of treatment in the past, please indicate:

When: _____

Provider: _____

Reason: _____

Results: _____

Have you ever been prescribed medications for psychiatric or emotional problems? ***Yes*** ***No***

If yes, please indicate all medications (past and current):

When: _____

Medication: _____

Prescriber of the medication: _____

Reason for medication: _____

General Health

Do you have any concerns about your physical health? Please explain:

_____

Are you on any medication for physical/medical issues? ***Yes*** ***No***

Are there any changes or difficulties with your eating habits? ***Yes*** ***No***

If yes, please circle: Eating less Eating more Binging Restricting

Have you experienced any weight changes in the last 1-2 months? ***Yes*** ***No***

Are you having any trouble with your sleep habits? ***Yes*** ***No***

If yes, please describe: _____

List of Symptoms

Please circle any of the following that have been of concern recently.

Alcohol/Substance use	Fatigue	Mood swings
Aggression	Frustrated easily	Oppositional
Anger	Grief/Loss	Panic attacks
Anxiety	Hallucinations	Phobias
Bowel trouble	Headaches	PTSD symptoms
Bullies others	Head banging	Repetitive thoughts
Bullied by others	Health concerns	Relationship trouble
Compulsive	Homicidal thoughts	Sadness
Depressed mood	Hurting animals	Self-harm
Defiant	Impulsive	Sexual acting out
Destructive	Irritable	Stomach aches
Difficulty focusing/memory loss	Isolation	Stealing
Difficulty with communication	Lying frequently	Suicide thoughts/attempts
Disturbed sleep	Low self-esteem	Withdrawn
Eating disorder/Disordered eating		Worry excessively

Brief Trauma Screen

Have you ever been impacted by the following:

Domestic Violence	***Yes*** ***No***
Childhood Abuse	***Yes*** ***No***
Childhood Neglect	***Yes*** ***No***
Childhood Sexual Abuse	***Yes*** ***No***
Adult Sexual Abuse	***Yes*** ***No***
Witnessed Violence	***Yes*** ***No***
Victim of Violence	***Yes*** ***No***

Other traumatic events/situations: _____

Substance Use

Do you currently consume alcohol? ***Yes*** ***No***

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? ***Yes*** ***No***

Have family members or friends expressed concern about your drinking? ***Yes*** ***No***

Do you currently use non-prescribed drugs or street drugs? ***Yes*** ***No***

Do you have a history of problematic drug use? ***Yes*** ***No***

Do you have a family history of alcohol or drug problems? ***Yes*** ***No***

If yes, please describe: _____

Family/Individuals in Your Household

Name	Age	Gender	Relationship	Living with you?
_____	_____	_____	_____	***Yes*** ***No***
_____	_____	_____	_____	***Yes*** ***No***
_____	_____	_____	_____	***Yes*** ***No***
_____	_____	_____	_____	***Yes*** ***No***
_____	_____	_____	_____	***Yes*** ***No***

Family Mental Health History

Issue		*Family Member(s)*
Depression	***Yes*** ***No***	_____
Anxiety Disorder	***Yes*** ***No***	_____
Panic Attacks	***Yes*** ***No***	_____
Bipolar Disorder	***Yes*** ***No***	_____
Obsessive Compulsive Behavior	***Yes*** ***No***	_____
Schizophrenia	***Yes*** ***No***	_____
Alcohol/Substance Abuse	***Yes*** ***No***	_____
Learning Disability	***Yes*** ***No***	_____
Trauma History	***Yes*** ***No***	_____
Domestic Violence	***Yes*** ***No***	_____
Eating disorder	***Yes*** ***No***	_____

Other

What are your goals for therapy? What would you like to get out of your time in therapy?

_____

_____

_____

Anything else you would like me to know?

_____

_____

_____

Insurance Information

Primary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ___/___/____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

Secondary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ___/___/____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

I authorize Erin K. Gist, MA, LMHC, CMHS to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.

Signature: _____ Date: _____