

Adult Intake Form

NAME: _____
First Name Middle Initial Last Name

DOB: _____ **AGE:** _____ **GENDER:** Male Female

ADDRESS: _____ **APT.#:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____
Home Cell Work

E-MAIL ADDRESS: _____

IN CASE OF AN EMERGENCY PLEASE IDENTIFY ONE PERSON YOU AUTHORIZE YOUR CLINICIAN TO CONTACT:

NAME: _____ **PHONE NUMBER:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER _____

PLEASE LIST ALL PERSONS (INCLUDING YOURSELF) CURRENTLY LIVING IN YOUR HOUSEHOLD.

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>DOB</u>	<u>AGE</u>	<u>OCCUPATION/YEARS OF EDUCATION</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

DESCRIBE YOUR FAMILY, CULTURE AND RELIGIOUS CONNECTIONS: _____

WHO REFERRED YOU TO US: _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT: _____

IS TREATMENT COURT ORDERED? Yes No

SPIRITUALITY:

Would you describe your spiritual beliefs as producing: Comfort Stress N/A
 Are you an active participant in a religious community? Yes No N/A

Would you like the counseling process to include scripture discussion or prayer?

Scripture discussion: Yes No Prayer: Yes No

SUBSTANCE USE: (Please mark each that apply with "1" current and "2" past)

___ TOBACCO ___ ALCOHOL ___ NON-PRESCRIPTION DRUGS ___ OTHER

SELF/FAMILY MENTAL HEALTH HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

___ INDIVIDUAL THERAPY ___ MARITAL THERAPY ___ FAMILY THERAPY ___ SEX THERAPY
___ DOMESTIC VIOLENCE ___ ANGER MANAGEMENT ___ GROUP THERAPY ___ GRIEF
___ LOSS ___ ANXIETY ___ DEPRESSION ___ ADHD
___ SEXUAL ABUSE ___ PHYSICAL ABUSE ___ BIPOLAR DISORDER ___ EATING DISORDER
___ PSYCHIATRIC HOSPITALIZATIONS ___ SCHIZOPHRENIA ___ ANTISOCIAL BEHAVIOR (HISTORY OF VIOLATING THE LAW) ___ DRUG USE
___ ALCOHOL USE ___ OTHER SUBSTANCES ___ OTHER ADDICTIONS

SELF/FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

___ ASTHMA ___ HIGH BLOOD PRESSURE ___ KIDNEY DISEASE ___ DENTAL PROBLEMS
___ CANCER ___ THYROID PROBLEMS ___ LIVER DISEASE ___ TUBERCULOSIS
___ DIABETES ___ SEASONAL ALLERGIES ___ HEART DISEASE ___ HEAD INJURY
___ HEARING ISSUES ___ SEIZURES ___ ALLERGIES ___ OTHER

CURRENTLY PRESCRIBED MEDICATIONS AND PRESCRIBING PHYSICIAN:

CURRENT GENERAL FUNCTIONING: (Please mark each that apply.)

___ CHEERFUL/HAPPY MOOD MOST OF THE TIME ___ SAD OR TEARFUL MOST OF THE TIME ___ FEELINGS OF HOPELESSNESS/EMPTINESS
___ WITHDRAWN BEHAVIORS/ ISOLATION ___ DIFFICULTY CONCENTRATING ___ UNDER ACTIVE/SLUGGISH BEHAVIOR
___ DECREASE IN INTERESTS/ACTIVITIES ___ FEELINGS OF GUILT ___ DOWN MOST DAYS
___ DECREASED APPETITE ___ INCREASED APPETITE ___ WEIGHT GAIN
___ WEIGHT LOSS ___ NO ENERGY ___ OVERLY FATIGUED DURING THE DAY
___ SUICIDAL THOUGHTS ___ SUICIDE ATTEMPTS ___ INTENTIONAL SELF-HARM (I.E. CUTTING)
___ POOR SELF-CARE/POOR HYGIENE ___ POOR MEMORY ___ EXTREME UPS AND DOWNS IN MOOD
___ WORRY ___ PANIC ___ AVOIDANT
___ STRESS TAKES MORE THAN AN HOUR TO FALL ASLEEP ___ IRRITABILITY ___ ANGER
___ NIGHT WAKING FOR LONGER THAN 30 MINUTES
___ UNABLE TO SLEEP IN OWN BED THROUGH THE NIGHT ___ FEARFUL OF PLACES, SITUATIONS OR PEOPLE ___ HARD TO WAKE UP IN THE MORNING
___ FEARLESS/ENGAGING IN RECKLESS ACTIVITIES ___ EXAGGERATED VIEW OF ABILITIES ___ FAST/RAPID SPEECH FEEL RESTED AFTER 3-4 HOURS SLEEP
___ THREAT TO HURT SOMEONE WITH INTENT /PLAN ___ PHYSICAL AGGRESSION ___ LYING
___ STEALING ___ PHYSICAL CRUELTY TO ANIMALS ___ CONFLICT WITH AUTHORITY FIGURES
___ VERBAL THREATS TO HARM OTHERS ___ THOUGHTS OF HARM TO OTHERS ___ PROPERTY DAMAGE
___ INABILITY TO REMAIN SEATED

- | | | |
|--|---|---|
| _____ EXPLOSIVE OUTBURSTS | _____ DISTINCT PERIODS OF NONSTOP
ACTIVITY | _____ POOR SOCIAL SKILLS |
| _____ LEGAL PROBLEMS | _____ EXTREME CONFLICT WITH OTHERS | _____ GRANDIOSITY-UNREALISTIC SENSE OF
SUPERIORITY |
| _____ PROBLEMS WITH SCHOOL PERFORMANCE | _____ PROBLEMS WITH WORK PERFORMANCE | _____ INABILITY TO COMPLETE TASKS |
| _____ INABILITY TO SUSTAIN ATTENTION | _____ EASILY DISTRACTED | _____ OVERACTIVE/HYPERACTIVE |
| _____ IMPULSIVITY | _____ COMPULSIONS | _____ DENIAL |
| _____ NIGHTMARES | _____ SLEEPWALKING | _____ WETTING ACCIDENTS |
| _____ SEXUAL CONCERNS | _____ EXCESSIVE MASTURBATION | _____ PAIN DURING INTERCOURSE |
| _____ PROBLEMS WITH RELATIONSHIPS | _____ JEALOUSY | _____ BLENDED FAMILY |
| _____ DIVORCE | _____ MARITAL AFFAIR | _____ FAMILY CONFLICT |
| _____ MARITAL PROBLEMS | _____ TRUST | _____ ENABLING |
| _____ SHAME | _____ CRISIS | _____ CONCERNS WITH ELDER CARE |
| _____ CONCERNS WITH CHILD CARE | _____ DISABILITY | _____ EMPLOYMENT |
| _____ INTENTIONAL PURGING | _____ INTENTIONAL VOMITING | _____ HOARDING FOOD |
| _____ BINGE EATING | _____ ANOREXIA | _____ BULIMIA |
| _____ OBESITY | _____ BODY IMAGE | _____ SELF-ESTEEM |

AUTHORIZATION AND CONSENT

By signing below you are authorizing Heritage Family Counseling Services to provide you with mental health services. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Signature X _____ Date _____

BILLING INFORMATION: *If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.*

PAYMENT OPTION: INSURANCE SELF-PAY OTHER _____

PRIMARY INSURANCE POLICY INFORMATION:

Primary Insurance Company: _____
Insurance Member I.D. Number: _____ Insurance Group Number (or none): _____
Effective Date: _____

PRIMARY INSURANCE INSURED PERSON INFORMATION:

Client's relationship to insured (i.e. self, spouse, child, other): _____
Insured Name: _____
Insured's Street Address: _____
Insured's City: _____ Insured's State: _____ Insured's Zip Code: _____
Insured's Phone Number: _____
Insured's Date of Birth: _____ Insured's Gender: Male Female
Insured's Employer: _____

By signing this agreement below you agree to and acknowledge each of the following conditions.

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Heritage Family Counseling Services will notify you in writing.
4. You assume responsibility for any and all fees rendered associated with services including document preparation fees provided at Heritage Family Counseling Services.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a \$30.00 charge.
7. You are responsible for notifying Heritage Family Counseling Services of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow Heritage Family Counseling Services to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Heritage Family Counseling Services shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name _____ Date _____

Signature X _____