New_____ Re-Admit_____

Client Intake Information

Date_____

THIS SHEET MUST BE FILLED IN COMPLETELY

First Name_____ Last Name_____ MI__

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (cell)_____

E-Mail:_____

Birthdate___/____/____ Age_____ Gender:_____ Race/ethnicity_____

Employment Information

Place_____Phone_____Can we leave messages? Y / N

Name of Spouse/Guardian_____Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for insurance-copay-deductible-and/or payment_____

Signature of Responsible party **X**_____(Must be signed for services to begin)

Insurance Information

Primary Insurance_____Secondary Insurance_____

Phone_____Phone_____

Contract/ID#_____Contract/ID#_____

Group/Acct#_____Group/Acct#_____

Subscriber_____Subscriber_____

Subscriber Date of Birth_____Subscriber Date of Birth_____

Employer_____Employer_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ ___Self __Spouse __Child __Other_____

Emergency Information

In case of emergency, contact:

Name _____ Phone_____Relationship_____

Address_____ City_____ State_____ Zip_____

Current Medications_____

Allergies_____

Referral Source

How did you hear of our clinic (or from whom)?_____

Address_____ City_____ State_____ Zip_____

Phone_____ Relationship to referral source_____

Name:_____Date of Admission:_____

Please list any other professionals you are currently (or within the last year) working with:

Medical Doctor

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Psychiatrist/psychologist

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Probation officer

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Previous counselor

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Mental health hospitalization

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

Other

Name:_____
Address:_____
Phone #:_____ Fax #:_____
E-mail:_____
May I contact this person in regards to your treatment at Choices? _____Yes _____No

***Note**: The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above named person's written consent, specifying the release of this information in accord with Federal regulations.*

A separate release of information will be signed if you indicated ***Yes*** on any of the above.

Name:_____Date of Admission:_____

Presenting Problem (s):

Check any areas of your life or problems you are currently experiencing:

☐ School	☐ Self Harm	☐ Depression	☐ Domestic Violence
☐ Family	☐ Employment	☐ Suicidal thoughts	☐ Physical/sexual abuse
☐ Parents	☐ Self Esteem	☐ Anxiety/ Panic	☐ Pornography
☐ Behavioral	☐ Religious/spiritual	☐ Eating disorder	☐ Legal problems
☐ Friends/peers	☐ Communication	☐ Health Concerns	☐ Alcohol and/or drugs
☐ Bedwetting	☐ Grief	☐ Anger control	☐ Gambling

(If alcohol or drugs is checked please complete the substance use questionnaire)

Briefly describe the problem (s) you are having at this time:

_____
_____
_____
_____
_____
_____
_____
_____

Have you been hospitalized or received counseling for these or other problems in the past? Yes ☐ No ☐
If yes, when and where: _____
_____
_____

Past Diagnoses or Evaluations: _____
_____

Comments on Current/past Therapy Experience:

_____
_____
_____

Have you ever☐ considered,☐ made a plan or☐attempted suicide? ☐ Yes ☐ No
Explain:_____
_____

Family / Social Developmental History:

Parent's Marriages (relationships):	Married/Divorced	Siblings (names and ages):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name:_____Date of Admission:_____

Where were you raised and by whom?_____

_____

Have you or any family member been adopted, or placed in foster care? ☐ Yes ☐ No

Explain if yes:

_____

_____

_____

Primary Caregiver: ☐ Bio parents ☐ Bio Mom ☐ Bio Dad ☐ Bio Mom and step Dad/boyfriend

☐ Bio Dad and step Mom/girlfriend ☐ Adoptive Parent ☐ Grandparent (s) ☐ Foster Family

☐Other_____Current Caregiver (if different from above): _____

Are they able to support the family financially? ☐Yes ☐No _____

Place of Residence: ☐House ☐ Apartment ☐ Trailer ☐ Condo ☐ Agency Housing ☐ Other_____

Father's Occupation:_____ Education level:_____

Father was employed: ☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Mother's Occupation:_____ Education level:_____

Mother was employed: ☐Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Describe your parent's/caregiver's relationship with you, now and growing up:

Mother:_____

Father:_____

Other:_____

_____

Is either parent/caregiver experiencing a problem with ☐ Alcohol ☐ Drugs ☐ Violence

If yes, please explain:_____

_____

Number of Siblings: ____Natural _____Step ____Half Birth Order: First Middle Last

Relations with Siblings: ☐ N/A ☐ Positive ☐ Mixed ☐ Negative ☐ Abusive

Parental discipline was administered by whom?:_____ How?:_____

Do you believe you were ever abused (check all that apply)? ☐ Yes ☐ No

☐ Verbally ☐ Emotionally ☐ Mentally ☐ Physically ☐ Sexually

If yes, when and by whom?:_____

Who did you tell about it?_____

What was done?_____

Was anyone else in your family abused? ☐ Yes ☐ No

_____

Do you ☐ have a history of or ☐currently self harm: How? _____

_____

Name:_____Date of Admission:_____

List any significant events/adjustments/deaths in your life:_____

_____

_____

Social/Peers:

How many close friends do you have currently?_____ How much time spent with friends?_____

Perceived Acceptance by Peer Group: ☐ Good ☐ Mixed ☐ Poor

Do you have a friend whom you trust well enough to share your feelings with? ☐ Yes ☐ No

List any problems you have currently with peers: _____

What activities do you do with your friends? _____

_____

Favorite TV shows: _____ _____ _____

Favorite movies: _____ _____ _____

Favorite books: _____ _____ _____

Favorite video games:_____

Heroes: _____ _____ _____

Educational Background:

Current Grade: _____ School: _____ Average GPA:_____

School Status: ☐ Regular Classes ☐ Honor Classes ☐ Resource/Special Ed ☐ Home Schooled

Have you ever been diagnosed with any learning disorders? ☐ Yes ☐ No

Please explain how they affect school performance:_____

_____

Classroom Behavior: N/A No Problem Few Problems Class Clown Disruptive Bully

Easily Distracted Introverted Hx of Suspension/Expulsion-Most Recent:_____

Truancy/Absences: N/A Rare Often

Any grades repeated? ☐ Yes ☐ No If yes, why?_____

List any extracurricular or recreational activities, interests and hobbies, organizations or community activities you pursue:_____

_____

_____

Do you have plans to further your education? ☐ Yes ☐ No

If yes, when, where and for what?:_____

Employment/Financial History: (if not applicable skip to next section)

Current Employer/ Occupation:_____

Dates of employment:_____ Level of job satisfaction:_____

Employment history (last 3 years):

Employer:	Type of work:	Dates:
_____	_____	_____
_____	_____	_____

Name:_____Date of Admission:_____

Religious/Spiritual Background:

Do you believe in God or a Higher Power?: ☐ Yes ☐ No

Religious Preference/Denomination:_____ Is Spirituality important to you?: ☐ Yes ☐ No

Do you currently practice your spirituality/religion?: ☐ Yes How?_____ ☐ No

Legal History:

Are there any legal actions pending, or are you currently involved with the legal system? ☐ Yes ☐ No

If yes, please explain:_____

Are you currently involved with: ☐ CPS ☐ HHS ☐ Diversion ☐ Probation ☐ Parole ☐ Other

Name of officer or other case manager:_____

Have you ever been arrested or previously sentenced? ☐ Yes ☐ No

If yes, please list: *Charges/sentences/consequences* *dates:*

_____

_____

_____

Personal Information:

Developmental history: ☐ ALL within normal limits OR ☐ Abnormal in the following areas:

☐ Physical ☐ Psychological/emotional ☐ Social ☐ Intellectual/cognitive ☐ Academically

Any Prenatal Problems?

_____

_____

Toileting/Elimination: ☐ None ☐ Bed Wetting ☐ Daytime Wetting ☐ Soiling ☐ Eccentric Behavior

Attention/Concentration: ☐ No Problems ☐ Age-Appropriate ☐ Not finishing Assignments ☐ Fidgets

☐ Poor Concentration (ADHD already diagnosed) ☐ Disorganized ☐ Forgetful ☐ Impetuous

Current Ideation of Violence: ☐ None ☐ Self Injury ☐ Others (WHO_____)

Other Risk Taking Activities: ☐ None ☐ Shoplifting ☐ Purse Snatching ☐ Theft ☐ Abuse

☐ Breaking/Entering ☐ Burglary ☐ Sexual Promiscuity ☐ Drug Use/Possession ☐ Drug Sales

Have you viewed pornography in the last 6 months? ____ No ____Yes, in which form_____

Drugs used: ☐ Caffeine ☐ Alcohol ☐ Marijuana ☐ Nicotine ☐ Other (illicit/OTC):_____

Self Esteem: ☐ Very Positive ☐ Positive ☐ Mixed ☐ Negative ☐ Very Negative

What are some positives in your life and your positive qualities?:_____

_____

What are some negatives in your life and your negative qualities?:_____

_____

Name:_____Date of Admission:_____

What are your life goals?:_____

_____

If you could have three wishes, what would they be?

_____

_____

_____

_____

Parents/Caregivers: (please complete about the child/adolescent)

What do you see as the child's strengths?_____

_____

What do you see as the child's weaknesses?_____

_____

Family history of alcohol, drug abuse or violence? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Knowledge of child's drug or alcohol abuse, sexualized behavior or self harm:_____

_____

Elaborate on previous questions or provide other information important to therapy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Treatment Plan

List two or three goals you would like to achieve in therapy:

#1. _____

#2._____

#3._____

Name:_____Date of Admission:_____

Family History

	Name	Currently Living?	*Significant health, medical, dental or mental health problems*
Spouse:	_____	Y / N	_____
Children:	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
Siblings :	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
	_____	Y / N	_____
Mother :	_____	Y / N	_____
Father :	_____	Y / N	_____

Personal Past and Present Medical/Emotional Health History (dates of treatment and hospitalizations):

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:_____ Drug allergies:_____

Current Physician: _____ Date of last office visit/exam: _____

Address: _____ Phone:_____

Prescription and non-prescription drugs used in the last year: Write additional on back of sheet if needed.

Drug, Dose, Frequency	Physician	Start date and reason	Stop date and reason

Height: _____ Weight: _____ Satisfaction with appearance: Low Medium High

Recent Change in Weight? ____Y _____N _____Increase _____Decrease Dieting? ____Y ____N

Recent Change in Appetite? _____Y _____ N _____Increase _____Decrease

Sleep disturbances: ☐ None ☐ Insomnia ☐ Frequent Waking ☐ Decreased ☐ Restlessness ☐ Increased

☐Nightmares ☐ Sleep apnea ☐ Narcolepsy ☐ Sleep Walking ☐ Other:_____

Drug history (past and present): ___ Nicotine ___ Alcohol ___ Caffeine ___ Other

Frequency_____

Please rate your overall health: ___ Poor ___ Fair ___ Good ___ Excellent _____