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Pasadena, TX 77505
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281-769-2238

ADULT INTAKE FORM

GENERAL INFORMATION

Name:____ Today's Date:______________

Your age: ______________ Date of Birth (DOB):___________________________

Address:____

____

Spouse or Partner's Name (if applicable): ____

Emergency Contact: ____________________________Emergency Contact Number: _______________________

Home phone:____ May I leave a message? Yes No

Cell phone:____ May I leave a message? Yes No

May I leave a ***text*** message? Yes No

Work phone:____ May I leave a message? Yes No

Email: ____ May I email you? Yes No

Referred by:____

What is the <u>main reason</u> you're seeking help?____

____

How long has this been an issue? ____

What are your <u>goals</u> for therapy?____

____

____

MENTAL HEALTH INFORMATION

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

____

____

Have you ever been hospitalized for mental illness? If so, list when, where, & reason:

____

____

Have you ever experienced any situation that you would consider traumatic for you?

____

____

When you were a child, did you struggle with any of the following:			Age
Learning disabilities	Yes	No	________________
Hyperactivity	Yes	No	________________
Bed wetting	Yes	No	________________
School fears	Yes	No	________________
Teasing/Bullying	Yes	No	________________
Eating disorders	Yes	No	________________
Witnessing violence in the home	Yes	No	________________
Sexual, physical or emotional abuse	Yes	No	________________

If so, by whom? ____

FAMILY PSYCHIATRIC HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

MEDICAL CONDITIONS & HISTORY

Do you currently have any medical problems? ____

____

Have you ever been hospitalized for medical reasons? If so, list when, where and reason:

____

____

Do you have any unexplained aches, pains, nerve or joint pain?

____

____

Have you ever been treated for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

____

____

____

How many times a week do you exercise?____________What type and how many minutes? ______________

____

How would you describe your diet? ____

Do you have any concerns about your overall health? (If so, please describe)

____

____

MEDICATIONS & PHYSICIAN INFORMATION

Please list current prescription medications with dosage (psychiatric and general health):

____

____

____

Please list any previous psychiatric medications (with dosage and dates): ______________________________

____

Who is your primary care physician? ____

Who is your psychiatrist (if applicable)? ____

When was your last complete physical exam (month/year)? __________________________________

SUBSTANCE USE

Do you drink alcohol or use recreational drugs? If so, what kind and how often? ______________________

____

____

Do you or anyone close to you consider your use to be a problem? Yes No

FAMILY INFORMATION (Family of Origin)

Where were you born? ____

Where did you live most of your childhood? ____

	MOTHER	**FATHER**
Current age, or **if deceased date, age, and cause of death.**		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe each parent.		
How did you and each parent get along when you were growing up? Give some examples of things that you did together & feelings you had.		
Use 3 adjectives or more to describe your parents' relationship.		
How did your parents get along? What were any things they disagreed over?		
Years married/together (parents)		
If divorced or not together, your age at divorce.		
Reason for divorce/split		
Describe your relationship with step-parents (if any).		
List anyone else who lived with you or regularly cared for you.		
Were you adopted? Age?	**If so, please write any relevant information about your biological parents.**	
List any issues in your family growing up:		

Siblings

Please list all of your brothers and sisters in the order of birth (if applicable).

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

Children

Please list your biological, adopted or stepchildren (if applicable).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

INTIMATE RELATIONSHIPS & SOCIAL SUPPORTS

Are you currently married? Yes No How long?___________

Are you currently partnered/in a romantic relationship? Yes No How long? ___________

Do you have any concerns about your current marital or romantic relationship that you would like to discuss?

If so, what are they?____

____

____

____

Are you currently separated or divorced? Yes No How long? __________________

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication:

____

____

____

____

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? To whom can you turn to for emotional and other forms of support?

____

____

____

EMPLOYMENT & EDUCATIONAL INFORMATION

Are you currently employed? Yes No Are you currently a student? Yes No

What was the highest grade of education you completed? ____________________________________

Please describe your current work or academic situation: ____________________________________

____

____

Do you enjoy your work/school? Is there anything stressful about it? __________________________

____

INTERESTS/ACTIVITIES/SPIRITUALITY

What are some of your interests/hobbies & activities? ____________________________________

____

____

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :____

____

____

ADDITIONAL INFORMATION

Do you have any legal history or current legal problems or concerns you feel I should know about? For example, have you ever been charged with DWI/DUI, dealt with custody battles, legal issues related to crime, etc?

____

____

Have you experienced any unusually severe stresses during the last year? Yes No

If yes, please describe:____

____

____

____

____

What do you consider to be your strengths?____

What do you consider to be your areas of needed growth?____

Is there any other information you'd like to add?

____

____

____

____

How much are each of the following areas currently a problem for you? Please circle.

	Not at all **1**	**A little** **2**	**Somewhat** **3**	**Considerably** **4**	**Terribly** **5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Job/School	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder/Struggles	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Financial Agreement Form

I agree to the following financial payment and procedures:

1. To pay $120 for the initial assessment and $110 per 53-minute session thereafter.
2. To pay an hourly rate of $110 for educational services, including serving as an advocate at 504 meetings, ARD meetings, and transition meetings. To pay $.545 per mile for mileage incurred for travel.
3. To pay an hourly rate of $110 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, and treatment summaries.
4. Payment is expected at the beginning or end of each session, unless prior arrangements have been made.
5. ***Appointments not cancelled 24 hours in advance*** **may be charged a $50 no-show fee and must be paid before the next session.**
6. A $25 service charge will be added to all returned checks and must be paid at the next session.
7. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy only and does not guarantee that all fees will be covered by insurance
8. Explanation of any alternate payment plan:
   ____
   ____
   ____

☐ ***I would like Clearhope Counseling and Wellness Center to bill my insurance.***
Initials

INSURANCE INFORMATION

Name of Insurance Company: ____

Insurance Company Address: ____

(City)_________________________ (State)__________ (Zip Code)______________

Phone Number: ______________________

Subscriber Name: ____________________________ Date of Birth: _________________

Place of Employment: ____

Policy ID or Social Security Number: ___________________________________

Group Number: _________________

I understand the above payment procedures and I agree to this plan of payment.

Client Signature ____________________________________ Date ______________

Therapist Signature ____________________________________ Date ______________