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Adult Client Intake Form

Client Information **Date:** ____________________

Client Name: ____DOB: ______________________

Address: ____
Street City State Zip

Phone Numbers: ____
Home Work Cell

Email: __________________________________ Preferred Contact Number: **Home Work Cell**

SS# _________________ Employer __________________Occupation _____________________

Spouse/Partner Information

Name: ____DOB: _______________________

Address ____
Street City State Zip
Phone Numbers ____
Home Work Cell

Email: __________________________________ Preferred Contact Number: **Home Work Cell**

SS# __________________Employer __________________Occupation______________________

Insurance Information

Company: _______________________________________ Policy/Group #: _________________

Policyholder: __________________________________ ID#: _____________________________

Address of Co.: ____

Insurance Phone #: ____

Assignment of Benefits: *"I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of benefits to Shannon L. Johnson, LPC for the services provided."*

___________________________________ ______________________

signature date

Client Health History

Primary Care Physician: __________________________ Phone:_______________________

Describe significant present or past illnesses, injuries, or handicapping conditions:

____

Chronic Illness: ____

Terminal Illness: ____

What medications are you currently taking?

Medication	Dosage	Purpose

Have you ever had or are you currently having thoughts of:

Hurting yourself _______________________ Hurting someone else ____________________

Not wanting to live _____________________ Suicide attempt _________________________

Have you seen a therapist for any of these issues in the past or present? **Yes No**

Have you ever been hospitalized for mental health concerns? **Yes No**

Please explain:

____

____

Family History

Family Information (or other household members)

Name	Sex	Age	Relationship	Live At Home (Y/N)

Current Family Stressors

___Chronic illness of family member
___Death of significant person
___Divorce or separation
___Domestic Violence
___Family member absent
___Family member emotional problems
___Family member suicide
___Financial problems/job loss
___Frequent moves

___Other

Family history of emotional/behavioral problems, substance abuse, family violence, or criminal activity? **Yes** **No** If yes, please explain: ____
____

__**Current Concerns**__

Please indicate the following items that apply:

___Abuse (physical, emotional, sexual)
___Adjustment to life changes
___Drug or alcohol use
___Eating problems
___Family or step family relationships
___Feeling angry or irritable
___Feeling anxious
___Feeling sadness or depression
___Health concerns
___Illegal behaviors
___Non-family relationship problems
___Parent-Child relationships
___Birth of child
___Suicidal thoughts or attempts
___Unusual behavior/changes in behavior
___Other significant life events. Please explain:
____
____
____

Is anyone hurting you now? **Yes** **No** Please explain:
____

Please state the kind of alcohol and the frequency you consume alcohol, if any:____

Please state if you smoke marijuana or use other "street drugs" (this information is strictly confidential): ____

Briefly describe the problem that has brought you to therapy:
____

What are your goals of therapy:
____
____

__**Emergency Contact Information**__
Emergency Contact Person (other than household member)
Name: _________________________ Relationship ____________________

Home phone: ______________________________ Work phone: ______________________________

May I contact this person in the event of an emergency? **Yes** **No**

Signature