ACME CORPORATION

CLIENT INTAKE FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before your first visit, we need to collect some general information from you. ***Please write as legibly as possible*** *so we can read what you have provided us.*

GENERAL INFORMATION

FIRST NAME _____ LAST NAME _____

GENDER _____ DATE OF BIRTH _____ SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ OTHER PHONE _____

SUPPORTIVE LIVING ENTITY _____

PROGRAM MANAGER _____

PHONE _____ EMAIL ADDRESS _____

EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

PHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER _____

POLICY HOLDER DOB _____ RELATIONSHIP _____

POLICY HOLDER ADDRESS _____

CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE _____ POLICY HOLDER _____

POLICY HOLDER DOB _____ RELATIONSHIP _____

POLICY HOLDER ADDRESS _____

CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

FINANCIALLY RESPONSIBLE PARTY

FIRST NAME _____ LAST NAME _____

ADRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ OTHER PHONE/EMAIL _____

RELATIONSHIP TO PATIENT _____

PRIMARY CARE PROVIDER

NAME _____ PHONE NUMBER _____

PHARMACY

NAME _____ PHONE NUMBER _____

IMPORTANT!

Acme Corporation **DOES NOT** prescribe medications to our clients. You will need to contact your Primary Care Provider for assistance with any medication needs or other applicable Care Provider. No medication is onsite at our facility either. Thank you for your understanding.

Mental Health and Wellness Intake Form

Please, complete all the information on this form and bring it to the first visit. It may feel like it will take a significant amount of time, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you.

Name: _____ Date of Birth: _____ Gender: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Are you receiving mental health treatment at this time (Circle One)? Yes No

If **YES**, where: _____

_____

What mental health or addiction services are you seeking from Acme Corporation? (Circle all that apply.)

Psychiatry Therapy/counseling Intensive Outpatient

Why are you seeking addiction and/or mental health treatment at this time? (Provide up to three (3) reasons).

1. _____
2. _____
3. _____

What do you hope to gain from mental health treatment? What would you like to be different?

1. _____
2. _____
3. _____

What do you like about yourself? What are your personal strengths? _____

_____

What are your interests and hobbies? _____

_____

What is important to you? _____

_____

What helps you to feel calm? _____

Current Symptoms Checklist:

(Check for Any Symptoms Present, Twice for Major Symptoms)

☐	Depressed Mood	☐	Decreased Need for Sleep	☐	Concentration/ Forgetfulness
☐	Unable to Enjoy Activities	☐	Loss of Interest	☐	Changes in Appetite
☐	Increased Need for Sleep	☐	Decrease in Energy	☐	Change in Appetite

Other Symptoms:

(Check for Any Additional Symptoms Present as Provided Below)

☐	Excessive Guilt	☐	Anxiety Attacks	☐	Violent Thoughts
☐	Fatigue/Tiredness	☐	Avoidance	☐	Violence Towards Others/Anyone Specific? (Explain Below)
☐	Decreased Libido	☐	Increased Libido	☐	Hallucinations
☐	Racing Thoughts	☐	Suspiciousness	☐	Suicidal Thoughts
☐	Impulsivity	☐	Excessive Energy	☐	Increased Irritability
☐	Crying Spells	☐	Self-Harm (Explain Below)	☐	Suicide Thoughts (Explain Below)
☐	Risky Behavior (Explain Below)	☐	Other (Explain Below)		

If you have checked any boxes that require an additional explanation, please provide as many details as possible below:

_____

_____

_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes No

If **YES**, please, answer the following. If **NO**, please, skip to the next section.

Do you currently feel that you don't want to live? Yes No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Would anything make it better? _____

Do you have a plan to kill yourself? _____

Is the method you would use readily available? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill yourself before? _____

Do you have access to guns, weapons, medications, or anything you can hurt yourself with? Yes No

If **YES**, please, explain. _____

Medical Information:

Allergies (List All): _____

Weight _____ Height: _____

List ALL current prescription medications and how often you take them. List Over the Counter (OTC) medications or supplements in the next section, please.

Medication Name	Reason	Total Daily Dosage	Estimated Start Date

Current OTC Medications and/or Supplements

Medication/ Supplement Name	Reason

For Women only: Are you currently pregnant or do you think you may be pregnant? Yes No

Do you have any concerns about your physical health that you would like to discuss with us? Yes No

Date and place of last physical exam: _____

Personal and Family Medical History/Status

	You	Family Member(s)	Which Family Member(s)?
Anemia			
Asthma/respiratory problems			
Cancer (type)			
Chronic Fatigue			
Chronic Pain			
Diabetes			
Epilepsy or seizures			
Fibromyalgia			
Head trauma/ Traumatic Brain Injury			
Heart Disease			
High blood pressure			
High cholesterol			
Intellectual or Developmental Disability			
Kidney Disease			
Liver Disease/ problems			
Stomach or intestinal problems			
Thyroid Disease			
Other			

Past medical problems, non-psychiatric hospitalizations, or surgeries: _____

_____

_____

Have you ever had an EKG? Yes No

Was the EKG... Normal Abnormal Unknown

Mental Health History/Status

Have you participated in outpatient mental health treatment before? Yes No If YES, describe.

Reason for Outpatient Mental Health Treatment	Dates Treated	By Whom (Where)	Was it a Positive OR Negative Experience?

Have you been hospitalized for mental health treatment before? Yes No
If YES, describe.

Past Psychotropic Medications: If you have ever taken any of the following medications, please, indicate the dates and how helpful the medication was (If you can't remember all the details just write in what you do remember).

	Dates	Response/ Side-Effects
Antidepressants		
Anafranil (Clomipramine)		
Celexa (Citalopram)		
Cymbalta (Duloxetine)		
Effexor (Venlafaxine)		
Elavil (Amitriptyline)		
Lexapro (Escitalopram)		
Luvox (Fluvoxamine)		
Pamelor (Nortrptyline)		
Paxil (Paroxetine)		
Prozac (Fluoxetine)		
Remeron (Mirtazapine)		
Serzone (Nefazodone)		
Tofranil (Imipramine)		
Wellbutrin (Bupropion)		
Zoloft (Sertraline)		
Other		

	Dates	Response/ Side-Effects
Mood Stabilizers		
Depakote (Valproate)		
Lamictal (Lamotrigine)		
Lithium		
Tegretol (Carbamazepine)		
Topamax (Topiramate)		
Other		
Antipsychotics/Mood Stabilizers		
Abilify (Aripiprazole)		
Clozaril (Clozapine)		
Geodon (Ziprasidone)		
Haldol (Haloperidol)		
Prolixin (Fluphenazine)		
Risperdal (Risperidone)		
Seroquel (Quetiapine)		
Zyprexa (Olanzepine)		
Other		
Sedative/Hypnotics		
Ambien (zolpidem)		
Desyrel (Trazaodone)		
Restoril (Temazepam)		
Rozerem (Ramelteon)		
Sonata (Zaleplon)		
Other		
ADHD medications		
Adderall (Amphetamine)		
Concerta (Methylphenidate)		
Ritalin (Methylphenidate)		
Strattera (Atomoxetine)		
Other		
Antianxiety Medications		
Ativan (Lorazepam)		
Buspar (Buspirone)		
Klonopin (Clonazepam)		
Tranxene (Clorazepate)		
Xanax (Alprazolam)		
Valium (Diazepam)		
Other		

Substance Use

Have you had treatment for alcohol or drug abuse? Yes No

Which substances? _____

In the past three (3) months, what is the largest amount of alcohol you have consumed in one day? _____

Have you used street drugs in the past three (3) months? Yes No

Which drugs? _____

Have you ever abused prescription medication? Yes No

If **YES**, which one(s) and for how long? _____

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Has anyone said that you may have a problem with alcohol or drug use? Yes No

Do you think you may have a problem with alcohol or drug use? Yes No

Have ever tried the following?

	Yes	No	If YES, how long and when did you last use?
Alcohol			
Cocaine			
Ecstasy			
Heroin			
LSD or hallucinogens			
Marijuana			
Methadone			
Methamphetamine			
Pain killers (Not as Prescribed)			
Stimulant (Pills)			
Tranquilizer/ Sleeping Pills			
Other?			

Tobacco and Caffeine

How many caffeinated beverages do you drink a day?

Coffee _____ Sodas _____ Tea _____ Energy Drinks _____

Do you currently smoke? Yes No If YES, for how many years? _____

Pipe, cigars, or chewing tobacco: Currently use? Yes No

What kind? _____ For how many years? _____

Family Background and Childhood History

Ethnic/Cultural Background: _____

Were you adopted? Yes No

Where did you grow up? _____

Who did you live with when you were a child? _____

What was your relationship like with the person or people who raised you? _____

_____

How old were you when you left home? _____

Trauma History or Trauma Witnessed

Have you experienced any of the following?

Physical Abuse: Yes No

Emotional abuse: Yes No

Neglect: Yes No

Sexual Abuse as Victim: Yes No

Sexual Abuse as Perpetrator: Yes No

Have you witnessed anyone being abused? Yes No

Has anyone in your immediate family died? _____

Have you experienced any distressful or painful events that still bother you? Yes No

Please, elaborate on any YES responses. _____

_____

_____

Educational History

Highest grade completed? Where? _____

Did you participate in Special Education? Yes No

Describe. _____

Completed some college or vocational training? Yes No

Describe. _____

Completed four-year degree? Yes No

Describe. _____

Completed graduate degree? Yes No

Describe. _____

Do you need assistance with reading and writing? Yes No

Do you need an interpreter (sign language or language other than English)? Yes No

If **YES**, please describe. _____

Occupational History

Are you Currently... (Circle All That Apply):

Working
Unemployed, looking for work
Unemployed, not looking for work
Disabled
Retired
Student

Where do you work? _____For how long? _____

What kind of work have you done in the past? _____

Have you ever served in the military? Yes No

If **YES**, please describe. _____

Relationships and Current Living Situation

Are you currently: Single Married Divorced Widowed Partnered

How long have you been married or partnered? _____

How long have you been divorced or widowed? _____

If you are not married or partnered, are you currently in a relationship? Yes No
Describe your relationship with your spouse/ significant other. _____

How would you identify your sexual orientation (Choose One)?

Straight/Heterosexual
Lesbian/Gay/Homosexual
Bisexual
Transgender
Unsure/Questioning
Asexual
Other _____
Prefer Not to Answer

Where do you live?

Alone, without Paid Supports
Alone, with Paid Supports
Supported Housing/Living
With Family/Significant Other/Natural Supports
Other _____

Who lives with you?

Name	Relationship

Legal

Have you ever been arrested? Yes No Describe. _____

Do you have any pending legal problems? Yes No Describe. _____

Spiritual/Religious

What is your religious preference (if applicable)?

_____

Do you find your involvement helpful during this time in your life? Yes No

How does practicing your religion help you?

Describe. _____

Is there anything else you would like us to know?

_____

_____

_____

Who helped you to complete this form (if applicable)?

_____