

Building Foundations Counseling Center, Inc.
A Professional Family Counseling Corporation

Adult Intake Form

PATIENT INFORMATION				
Patient Name:		Patient's Date of Birth:	Current Age:	Gender: Today's Date:
Address:		City:	State:	Zip:
Home Phone:		Cell Phone:	Work Phone:	
May we identify this clinic when leaving a message at either or both of these numbers? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Ethnicity:		Occupation/Job Title:	Highest Educational Level Achieved:	
Social Security Number:			Email:	
REFERRAL INFORMATION				
Reason for Referral: <input type="checkbox"/> Individual <input type="checkbox"/> Couples <input type="checkbox"/> Family <input type="checkbox"/> Group Therapy <input type="checkbox"/> Other: _____				
Referred By:		Phone:	Address:	
INSURANCE INFORMATION				
How do you intend to pay for services? <input type="checkbox"/> Private Pay <input type="checkbox"/> Insurance <input type="checkbox"/> Victim Witness <input type="checkbox"/> EAP <input type="checkbox"/> Other: _____				
Insurance Name:			Insurance Phone Numbers:	
Insurance Address:			Subscriber's Name:	
Subscriber's Social Security Number:		Subscriber's Date of Birth:	Relationship to Patient:	
Member ID#:			Group ID#:	
Name and Address of Employer:			Employer's Phone Number:	
Is there secondary insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO			Secondary Insurance Name:	
Insurance Address:			Subscriber's Name:	
Subscriber's Date of Birth:		Member ID#:	Group ID#:	
Victim Witness Claim #	Victim Witness Date of Incident:	EAP Authorization #:	EAP # Sessions	
EMERGENCY CONTACT				
Name:		Phone:	Relationship to You:	

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MEDICAL INFORMATION					
Primary Physician Name:			Phone:		
Medications Currently Taking:					
Medical Conditions:					
May we have your permission to contact your primary care physician to coordinate your treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Please describe your overall health today:			Have you ever been in a 12-Step program? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please explain:		
Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, how often?		If YES for how long?	
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, how much alcohol do you consume in a week?			
Do you drink caffeine? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, how much caffeine do you consume in a day?			
Do you currently use illegal drugs or misuse medications? <input type="checkbox"/> YES <input type="checkbox"/> NO			If YES, describe your use:		
Have you ever used illegal drugs or misused medications? <input type="checkbox"/> YES <input type="checkbox"/> NO			If YES, please explain:		
MENTAL HEALTH TREATMENT					
	YES	NO	Name of Clinic or Person	List of Diagnoses, Medication, Type of Counseling or Service	Comments
Counseling Services:					
Psychiatric Treatment:					
Drug/Alcohol Treatment:					
Hospitalizations:					
Are you currently having any suicidal thoughts? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, please explain:			
Have you ever attempted to harm yourself currently or in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, please explain:			
Are you currently having any homicidal thoughts? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, please explain:			
May we contact your current/recent treating psychiatrist listed above to coordinate your treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					
May we contact your previous treating therapist or counselor above for continuity of care? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					
FAMILY MEMBERS/SIGNIFICANT OTHERS LIVING IN HOME OR IN YOUR LIFE					
Name:			Age:	Relationship:	
Name:			Age:	Relationship:	

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FAMILY MEMBERS/SIGNIFICANT OTHERS LIVING IN HOME OR IN YOUR LIFE - Continued

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

CURRENT CONCERNS AND SYMPTOMS

Please describe the problems for which you are seeking help at this time:

How long have you been concerned about these problems?

Do you notice any times that these symptoms/behaviors increase or decrease?

Please check if there have been any recent changes in the following:

<input type="checkbox"/> Sleeping Patterns	<input type="checkbox"/> Alcohol Consumption	<input type="checkbox"/> Behavior	<input type="checkbox"/> Physical Activity Level
<input type="checkbox"/> Eating Patterns	<input type="checkbox"/> Energy Level	<input type="checkbox"/> Weight	<input type="checkbox"/> Nervous/Tension
<input type="checkbox"/> Sex Drive	<input type="checkbox"/> Other: _____		

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

<input type="checkbox"/> Aggression	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Procrastinating
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Recurring Thoughts
<input type="checkbox"/> Anger	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Relationship Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Drug Dependence	<input type="checkbox"/> Irritability	<input type="checkbox"/> Repetitive Behaviors
<input type="checkbox"/> Anxiety/Panic Attacks	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Judgment Errors	<input type="checkbox"/> Sadness/Frequent Crying
<input type="checkbox"/> Avoiding People	<input type="checkbox"/> Elevated Mood	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Sick Often
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Memory Impairments	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Cyber Addiction	<input type="checkbox"/> Fearful	<input type="checkbox"/> Mood Shifts	<input type="checkbox"/> Thoughts Disorganized
<input type="checkbox"/> Depression	<input type="checkbox"/> Gambling	<input type="checkbox"/> Nightmares/Night Terrors	<input type="checkbox"/> Withdrawing
<input type="checkbox"/> Difficulty Working	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Phobias/fears	<input type="checkbox"/> Worrying
		<input type="checkbox"/> Pornography	<input type="checkbox"/> Other: _____

Are there any factors/events in your life that are contributing to your symptoms?

<input type="checkbox"/> Problem with Children	<input type="checkbox"/> Remarriage/Blended Family Issues	<input type="checkbox"/> Financial Stress
<input type="checkbox"/> Problem with Parents	<input type="checkbox"/> Work Related Stress	<input type="checkbox"/> Legal Problems
<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Recent Loss of a Loved One	<input type="checkbox"/> Trauma or Abuse
<input type="checkbox"/> Recent Divorce	<input type="checkbox"/> Problems with Friends/Co-Workers	<input type="checkbox"/> Other: _____

Are there any cultural values or spiritual beliefs that you feel would help therapist to understand you better?

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GOALS FOR THERAPY

What are your goals/wishes/expectations of therapy?

Is there any other information that would assist the therapist in understanding your current concerns/problems?