BRIEF INTAKE INFORMATION & MEDICAL/PSYCHIATRIC HISTORY

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BRIEF INTAKE INFORMATION

Client Name: ________________________________ Social Security # ______________________________

Birthday:____________________________________ Age: _____________ Sex:______________________

Mark one of the following: ☐Married ☐Single Adult ☐Separated ☐Divorced ☐Widowed ☐Minor

Street Address: ____

City, State, Zip: ____

Hm. Ph.: ( )___________________ Cell Ph. ( )____________________ Wk Ph. ( )______________

Email: ____

Highest level of education: ______________ Name of school attended: _______________________________

Current School or Employer & job title: ____

Emergency Contact Name and Number:____

Relationship to you: ____

May we call you at home? **Y N** Leave a message? **Y N** May we call you at work? **Y N**

PERSON RESPONSIBLE FOR ACCOUNT (If other than client) Relationship to Client: ____________

Name, Address & Phone: ____

____

INSURANCE INFORMATION

Name of Policy Holder: _______________________________ DOB/SS#: ____________________________

Address, City & Zip: ____ Phone: _________________________

Policy Name and Number: ____________________________________ Employer: ______________________

MEDICAL & PSYCHIATRIC HISTORY

Client's *Primary Care Physician* Name & Number: ____

List any prescription/over the counter drugs you currently take: _________________________________

____

Please mark any area(s) for which you currently or previously had problems or concerns:

☐ Anxiety ☐ Depression ☐ Behavioral ☐ Marriage ☐ Substance Abuse

☐ Stress ☐ Anger Management ☐ Suicidal Ideation ☐ Other ______________

Have you seen any of the following professionals before? (*Please list their name and dates seen.*)

Psychiatrist ____

Psychologist ____

Counselor ____

Social Worker ____

History of substance use:

Cigarettes: ☐NO ☐ YES How long? _____________ How Often? ____________

Alcohol: ☐NO ☐ YES How long? _____________ How Often? ____________

Illicit drugs: ☐NO ☐ YES How long? _____________ How Often? ____________

Family History of Substance Abuse: (mark all that apply)

☐ Mother ☐Maternal Grandmother ☐ Grandfather ☐ Aunt ☐Uncle

☐ Father ☐ Paternal Grandmother ☐ Grandfather ☐ Aunt ☐Uncle

Family history of mental health conditions? **NO YES** If yes, please explain: _________________________

____

____

Other information you would like the counselor to know: _______________________________________

____

______________________________ ______________________________

Client Signature & Date *Legal Representative & Date*