Adult Intake Form

Name: ____ Date of Birth: ______________

Legal Name (if different): ____ Gender: ❑ M ❑ F

Address: ____

Email: ____

Primary Contact Number: ______________________________________ ❑ Home ❑ Work ❑ Cell

Alternative Contact Number: ___________________________________ ❑ Home ❑ Work ❑ Cell

Insurance Information

Primary Health Insurance Company:____

Policy Holder Name:____

Policy Holder DOB :____________________ Policy Holder Social Security # : ____________________

Policy Holder ID #:__________________________ Group/ Policy #:__________________________

Additional Health Insurance Company:____

Policy Holder Name:____

Policy Holder DOB :____________________ Policy Holder Social Security # : ____________________

Policy Holder ID #:__________________________ Group/ Policy #:__________________________

Type of Additional Coverage: ❑Secondary ❑EAP (Employee Assistance Program)

Client Authorization

I understand that I am fully responsible for any fees for professional services provided to me or to my dependents. My signature below authorizes Seacoast Youth Services to submit claim forms for me directly to my insurance company, but does not guarantee payment of claims. I authorize the release of any medical or other information required by my insurance company to receive authorization for services or to process claims for services to me to my dependents.

Signature _________________________________ Date __________________________

Marital Status

❑ Single ❑ Divorced (_____ years) ❑ Committed Relationship (_____ years)

❑ Married (______ years) ❑ Separated (_______ years) ❑ Widowed (______years)

Spouse/Partner's Name:____

Emergency Contact Information

Name: ____

Address: ____

Phone:( ) ______________________________ Relationship to you: ________________________

Primary Care Physician

Current Physician:____

Physician Address: ____

Physician Phone Number :( )_____________________ Date of Last Exam _____________________

Referent

By whom were you referred? ____

Presenting Problems and Concerns

Describe the problem that brought you here today:

Please mark all of the items below that apply, and feel free to add any others at the bottom.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, work problems, employment, workaholism/overworking
- ❑ Childhood issues (your own childhood)
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Health, illness, medical concerns, physical problems
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility , Judgment problems
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Relationship problems, Interpersonal conflicts (with friends, relatives, or at work)
- ❑ School problems
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Stress, stress management, tension
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Threats, violence
- ❑ Weight and diet issues, overeating, under eating, appetite, vomiting
- ❑ Withdrawal, isolating

Other concerns or issues:

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Attention Deficit Disorder or Hyperactivity	
Sexually Abused	
Depression	
Suicide	
Anxiety or Panic Attacks	
Obsessive-Compulsive	
Anger/ Abusive	
Schizophrenia	
Eating Disorder	
Alcohol or Drug Abuse	
Other:	

❑ Parents legally married or living together

❑ Parents temporarily separated

❑ Parents divorced or permanently separated

❑ Mother remarried: Number of times:______

❑ Father remarried: Number of times:______

Please check if you have experienced any of the following types of trauma of loss:

❑ Sexual Abuse ❑ Physical Abuse ❑ Violence in the home ❑ Parent Substance Abuse ❑Neglect

❑ Lived in a foster home ❑ Homelessness ❑ Teen Pregnancy ❑ Placed a child for adoption

❑ Parent illness ❑ Crime Victim ❑ Multiple family moves ❑ Loss of a loved one ❑ Financial Problems

Previous Mental Health Treatment

Type of Treatment	When	Provider/Program	Reason for Treatment
❑ **Outpatient Counseling**			
❑ **Medication (mental health)**			
❑ **Psychiatric Hospitalization**			
❑ **Drug/Alcohol Treatment**			
❑ **Self-help/Support Groups**			

Substance Use History

Substance Type	Current Use (Last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Have you had withdrawal symptoms when trying to stop using any substances? ❑ Yes ❑ No

If yes, please describe:____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?

❑ Yes ❑ No If yes, please describe: ____

Medical Information

Have you ever experienced any of the following medical conditions during your lifetime?

❑ Allergies ❑ Asthma ❑ Seizures ❑ Vision problems
❑ Headaches ❑ Stomach aches ❑ High fevers ❑ Diabetes
❑ Chronic pain ❑ Surgery ❑ Sleep disorder ❑ Miscarriage
❑ Serious accident ❑ Head injury ❑ Sexually transmitted disease ❑ Abortion
❑ Dizziness/fainting ❑ Meningitis ❑ Hearing problems ❑ Other :___________________

Please list any current health concerns: ____

Current prescription medications:

Current Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

____

Allergies and/or adverse reactions to medications: ❑Yes ❑No

If yes, please list: ____

Interpersonal/ Social/ Cultural Information

Please describe your social support network (check all that apply):

❑ Family ❑ Friends ❑ Neighbors ❑ Students ❑ Community Group ❑ Co-workers

❑ Religious/Spiritual Center (which one) _________________________ ❑ Support/ Self-Help Groups

To which cultural or ethnic group do you belong? ____

How important are spiritual matters to you? ❑ Not at all ❑ Little ❑ Somewhat ❑ Very much

Would you like spiritual/ religious beliefs to be incorporated into your counseling? ❑Yes ❑No

Please describe your strengths, skills, and talents:

Describe any special areas of interest or hobbies (art, books, physical fitness, ect.):

Employment

Employer: ____ Position: _______________________________

Length of time in this position:_________________________ Stress level: ❑ Low ❑ Medium ❑ High

Job Duties: ____

Other jobs you have held: ____

Education

Are you currently attending school? ❑ Yes ❑ No

❑ **High School** Year_______ ❑ **GED** Year _______
❑ **Associate's Degree** Year_______ Major area of study: _________________________
❑ **Undergraduate Degree** Year _______ Major area of study: _________________________
❑ **Graduate Degree** Year _______ Major area of study: _________________________

Military Service

Have you been /are you currently in the military? ❑ Yes ❑ No (If no, skip remainder of this section)

Branch:______________________________________ Rank:_________________________________

Date of Discharge:___________________________ Type of Discharge:___________________________

Were you in combat? ❑ Yes ❑ No

Legal

Have you ever been convicted of a misdemeanor? ❑ Yes ❑ No

If yes, please explain:____

Are you currently involved in any divorce or child custody proceedings? ❑ Yes ❑ No

If yes, please explain: ____