A New Tomorrow
Behavioral Health Services

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ADULT INTAKE PACKET

General Information:

Date: ________________

Patient's Full Name: ____ Gender: ______________

Date of Birth: _______________ Social Security Number: _____________________ Age: _____________

Address: ____
Street City/State Zip

Home Phone: ______________________ Ok to leave message? Yes No

Cell Phone: ________________________ Ok to leave message? Yes No

Work Phone: _______________________ Ok to leave message? Yes No

Email: ____

Family Information:

Marital Status (circle one)

Single Living with Partner Married Separated Divorced Widowed

Rate quality of present relationship / marriage (if applicable):

____ very good ____ good ____ fair ____ poor ____ very poor

Your Occupation: ____

Occupation of Spouse / Partner: ____

Children and Ages:

____
____
____

If divorced, what are the custody arrangements?

____
____
____

Who currently resides in your home?

____
____

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
___	Mental Retardation	______________________
___	Speech or Communication Disorder	______________________
___	Attention Deficit/Hyperactivity/Impulsivity	______________________
___	Learning Problems/Developmental Disorder	______________________
___	Autism Spectrum/Asperger's Disorder	______________________
___	Sleep Disorders	______________________
___	Obsessive-Compulsive Disorder	______________________
___	Phobias	______________________
___	Anxiety	______________________
___	Depression	______________________
___	Manic-Depression/Bipolar Disorder	______________________
___	Suicide Attempts/Suicide	______________________
___	Schizophrenia or other psychosis	______________________
___	Alcohol/Substance Abuse	______________________
___	Seizures or other neurological disorder	______________________
___	Genetic Disorder (e.g., Down Syndrome, Fragile X)	______________________

Other: ____

Medical Information:

Primary Care Physician: ____

When was your last physical exam? Any relevant findings?

____

____

Are there any other physicians you see on a regular basis?

____

____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

____

____

____

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

____

____

____

Client Psychiatric History:

Has the client had prior mental health counseling? ___ yes ___ no

Describe previous mental health services you have received (evaluations and therapy). Include any diagnosis and length of treatment.

____

____

____

Is there a history of mental illness in the family? ___ yes ___ no

Explain:

____

____

Presenting Concern:

Present psychological difficulties – please check any that apply to you at this time.

___ Generalized Anxiety (across many situations)

___ Specific fears/phobias (list): ____

___ Panic attacks

___ Social Anxiety

___ Obsessive thinking or compulsive behaviors

___ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

___ Sadness or Depression

___ Emotionally overwhelmed

___ Frequent crying

___ Loss of energy

___ Loss of pleasure in life

___ Self-injurious/Self-harm behavior

___ Thoughts of suicide

___ Problems with eating

___ Problems falling asleep

___ Problems sleeping through the night (middle of the night waking or early morning waking)

___ Trouble waking up

___ Fatigue/tiredness during the day

___ Nightmares

___ Problems with attention or concentration

___ Racing thoughts

___ Problems making or keeping friends

___ Problems controlling anger

___ Relationship/Marriage problems

___ Problems with intimacy

___ Problems with job

___ History of abuse (emotional, physical, sexual)

___ Alcohol/drug use/abuse

___ Financial problems

___ Legal situation

Other: ____

Legal History

Have you ever filed or been involved in any litigation? Please explain

____

____

Is there anything else we should know about you that was not covered by this form?

____

____

Insurance:

Primary Insurance: ______________________________ ID Number: ________________________

Name of Insured: _________________________________ Insured's Date of Birth: _____________

Insured Address: _____________________________________ Phone: ______________________

Secondary Insurance: ____________________________ ID Number: ________________________

Name of Insured: _________________________________ Insured's Date of Birth: _____________

Insured Address: _____________________________________ Phone: ______________________

Responsible Party:

Name: _______________________________________ Relationship: _______________________

Address:____

Primary Phone: ____________________________ Alternate Phone: _________________________

I authorize this provider to release any information, including diagnosis, treatment plans / records to third party payers and / or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the provider or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office. I accept responsibility and understand that I am responsible for the charges and fees that are due at the time service is provided, unless I make arrangements in advance.

Signature: ____ Date: _______________________