**A New Tomorrow**

**Behavioral Health Services**

**26 Wesmark Ct., Sumter, S.C. 29150**

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**ADULT INTAKE PACKET**

# General Information:

Date:

Patient’s Full Name: Sex:

Gender Identity (Optional): Sexual Preference (Optional):

Date of Birth: Social Security Number: Age:

Race/Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:

Spiritual / Cultural Factors (Optional):

Please Describe Your Social Interactions:

# 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:

Education Level:

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

Intellectual Disability

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: