**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:

Emergency Contact Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to leave messages? \_\_\_\_\_\_\_

Spiritual / Cultural Factors (Optional):

Please Describe Your Social Interactions:

# Family Information:

Marital Status (circle one)

Single Living with Partner Married Separated Divorced Widowed Remarried

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

very good good fair poor very poor

Your Occupation and Job satisfaction:

Your Education Level:

Special accommodations needed for therapy (including technology, literacy needs, translation need):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation of Spouse / Partner:

Children and Ages:

If divorced, what are the custody arrangements?

Who currently resides in your home? What is your current living situation?

**Please check any that apply (or history of any below)**

\_\_\_\_\_ Discrimination due to Race

\_\_\_\_\_ Discrimination due to Ethnicity

\_\_\_\_\_ Discrimination due to sexual orientation

\_\_\_\_\_ Discrimination due to Gender Identity

\_\_\_\_\_ Discrimination due to Religion

\_\_\_\_\_ Discrimination due to mental or physical disability

\_\_\_\_\_ Food Insecurity

\_\_\_\_\_ Housing Insecurity

\_\_\_\_\_ Lack of transportation/insecurity

\_\_\_\_\_ Lack of employment

\_\_\_\_\_ Lack of childcare/insecurity

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 Abuse

Drug Abuse (Including Nicotine and Vapes)

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 or physical health conditions that you have been diagnosed as having (pregnancy, diabetes, physical disabilities, etc.) and any medical procedures you have had (surgeries, etc.) and the impact of these.

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, supplements and past medications prescribed. Please indicate the effectiveness of each medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medication allergies or adverse reactions to medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# List any holistic medical practices you engage in (chiropractic, yoga, messages ect.):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# 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:

# History of Trauma:

# Please describe any trauma that is/was experienced or witnessed including but not limited to Abuse, Neglect, Violence or Sexual Assault:

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 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

Suicidal thoughts or attempts

\_\_\_ Intent or Attempt to harm others

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 use

* + - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_

\_\_\_\_ Nicotine use (Vapes and E-cigarettes included)

* + - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_

\_\_\_\_ Illegal Drug use

* + - if yes, current use? \_\_\_\_\_\_
    - history of use? \_\_\_\_\_\_
    - how often per week? \_\_\_\_

Financial problems

Legal situation

Any other risk taking behaviors:

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Legal History

Have you ever filed or been involved in any litigation? Include any family court or DSS cases. Please explain

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

# 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_