BAYSIDE THERAPY ASSOCIATES ADULT INTAKE FORM

INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Date: _____ Form filled out by: □ Self □ Other: _____
Client Name: _____ Date of Birth: _____ Age: _____
Gender: □Female □Male □_____ Social Security #: _____
Referred By: _____ Primary Care Doctor: _____

Address: _____ City/State/Zip: _____
Home Phone #: _____ Cell #: _____ Work Phone #: _____
OK to leave message? □**YES** □**NO** □**YES** □**NO** □**YES** □**NO**
Employer: _____ Employer Address: _____

Emergency Contact: Name: _____ Relationship to you: _____
Home Phone #: _____Cell #: _____ Work #: _____

PRIMARY INSURANCE

□ **No Insurance Coverage**
Insurance Co.: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name:_____
Date of Birth:_____ SS #:_____
Relationship to you: _____

SECONDARY INSURANCE

Insurance Co.: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name:_____
Date of Birth:_____ SS #:_____
Relationship to you: _____

Person Responsible for Account: □ Self □ Other (fill out below)
Name: _____ Address: _____
Home Phone #: _____ Work: _____ Cell: _____
SS#: _____ DOB: _____ Employer: _____

FOR OFFICE USE ONLY

Dates of Referral: _____ to _____Date First Consulted:_____
Number of Sessions: _____ Ded.: _____Co-pay/Co-ins: _____

Date	dx code	dx	Counselor Signature

SUBSTANCE USE

Check Past and Current Substance Use:									
	Past Use	How Often	**Current Use**	How Often		**Past Use**	How Often	**Current Use**	How Often
Hard Liquor					Tranquilizers/Sleeping Pills				
Beer/Wine					Inhalants				
Marijuana					Cocaine				
Speed/Amphetamine					Nicotine				
Heroin/Painkillers					Coffee				
Hallucinogens/Ecstasy					Soft Drinks				
PCP					Other				

Consequences of Substance Abuse: (check all that apply):

Hangovers
Seizures
Blackouts
Overdose
Withdrawal Symptoms
Medical Conditions
Changes
Loss of Control Amount Used
Sleep Disturbance
Assaults
Suicidal Impulse
Relationship Conflicts
Binges
Interference with School
Job Loss
Arrests

Psychiatric History:

Prior **Out**patient Therapy? □ Yes □ No Provider Name: _____ Was It Beneficial?: □ Yes □ No

Prior **In**patient Therapy? □ Yes □ No Facility Name: _____ Was It Beneficial?: □ Yes □ No

MEDICAL HISTORY

Describe Current Physical Health: □ Good □Fair □Poor

List all medications client is taking. Include non-prescription drugs and health supplements.

Drug Name	Date started	Purpose	Dosage	# Per Day
1.				
2.				
3.				
4.				
5.				

Prescribed By: _____

Do you have any allergies to medication? □ Yes □ No If yes, which ones? _____

Check any of the following you have had in the past three months:

□ Vision Problems
□ Stomach Aches
□ Memory Loss
□ Dizziness
□ Shortness of Breath
□ Back Pain
□ Head Injury
□ Weakness in Arms or Legs
□ Constipation
□ Loss of Consciousness
□ Chest Pains or Tightness
□ Hearing Loss
□ Convulsion/Seizures
□ Diarrhea
□ Chronic Pain
□ Fainting
□ Nausea or Vomiting
□ Unusual Bleeding
□ Menstrual Irregularities
□ Headaches
□ Abnormal Growth or Lump

Check any of the conditions you have had and the date of onset:							
Condition	**Date**	**Condition**	**Date**	**Condition**	**Date**	**Condition**	**Date**
ADD/ADHD		Autism		Hypoglycemia		Stomach Ulcer	
AIDS/HIV		Bipolar Disorder		Panic Attacks		Thyroid Problem	
Allergies		Cancer		Obsessive/Compulsive		Skin Problem	
Alzheimer's/Dementia		Cutting		Learning Disability		Other:	
Anemia		Depression		Low Blood Pressure			
Anger Problems		Diabetes		High Blood Pressure			
Anxiety		Eating Disorder		Obesity			
Arthritis		Head Trauma		Migraine			
Asthma		Heart Disease		Seizure Disorder			

Is there a history of any of the following in your family:											
	GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING
Alcoholism				Birth Defects				Mental Retardation			
Alzheimer's Disease/Dementia				Cancer				Obsessive/Compulsive			
Panic Disorder				Depression				Anger Problems			
Anxiety Disorder				Diabetes				Schizophrenia			
ADD/ADHD				Drug Abuse				Seizure Disorder			
Behavior Problems				Heart Disease				Suicide/Homicide			
Bipolar Disorder				High Blood Pressure				Thyroid Problem			
Violent/Abusive Behavior				Aspergers/Autism							

Describe Any Hospitalization, Surgeries or Accidents

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

SOCIAL-ECONOMIC HISTORY: (check all that apply for client)

Marital Status:
- □ Single, Never Married
- □ Engaged _____ Months
- □ Married _____ Years
- □ Divorced _____ Years
- □ Separated _____ Years
- □ Divorce in Process
- □ Live-in for _____ Years
- □ Widowed _____ Years

Employment:
- □ Employed and Satisfied
- □ Employed but Dissatisfied
- □ Unemployed
- □ Coworker Conflict
- □ Supervisor Conflict
- □ Unstable Work History
- □ Disabled: _____ Retired

Financial Situation
- □ No Current Financial Problems
- □ Impulsive Spending
- □ Current Legal Issues
- □ Poverty or Below-Poverty Income
- □ Large Debt

SOCIAL-ECONOMIC HISTORY: (Continued): (check all that apply for client)

Military History:
- □ Never in Military
- □ Served in Military – No Combat
- □ Served in Military –With Combat

Social Support System:
- □ Supportive Network
- □ Few Friends
- □ No Friends
- □ Distant From Family of Origin

Education:
- □ Did Not Complete High School
- □ Completed High School
- □ GED
- □ Years of College _____
- □ College Degree: _____

Cultural/Spiritual (e.g., ethnicity, religion): _____

List persons living in clients home:		
Name	Age	Relationship to client
List children not living in the home:		
Name	Age	Relationship to client

TREATMENT GOALS:

Please list issues to discuss in therapy and specific goals you wish to accomplish:

_____

_____

_____

_____