

DISCOVERY COUNSELING ASSOCIATES ADULT INTAKE FORM

PLEASE COMPLETELY FILL OUT ALL PAGES.

Date: _____	Form filled out by: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____
Client Name: _____	Date of Birth: _____ Age: _____
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Referred By: _____	Primary Care Doctor: _____

Address: _____	City/State/Zip: _____
Home Phone #: _____	Cell #: _____ Work Phone #: _____
OK to leave message? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Employer: _____	Employer Address: _____

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

<u>PRIMARY INSURANCE</u>
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: _____

<u>SECONDARY INSURANCE</u>
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: <input type="checkbox"/> Self <input type="checkbox"/> 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: _____

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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Hangovers | <input type="checkbox"/> Medical Conditions | <input type="checkbox"/> Relationship Conflicts |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of Control Amount Used | <input type="checkbox"/> Binges |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Interference with School |
| <input type="checkbox"/> Overdose | <input type="checkbox"/> Assaults | <input type="checkbox"/> Job Loss |
| <input type="checkbox"/> Withdrawal Symptoms | <input type="checkbox"/> Suicidal Impulse | <input type="checkbox"/> Arrests |

Psychiatric History:

Prior **Outpatient** Therapy? Yes No Provider Name: _____ Was It Beneficial?: Yes No
 Prior **Inpatient** 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	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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Weakness in Arms or Legs | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pains/tightness | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Unusual Bleeding |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Convulsion/Seizures | <input type="checkbox"/> Menstrual Irregularities |
| <input type="checkbox"/> Head Injury | | <input type="checkbox"/> Headaches |

Check Any of the Conditions You Have Had and the Date of Onset:

Condition	Date	Condition	Date	Condition	Date
ADD/ADHD		Cancer		Learning Disability	
AIDS/HIV		Diabetic		Low Blood Pressure	
Allergies		Epilepsy		High Blood Pressure	
Anemia		Head Trauma		Obesity	
Arthritis		Heart Disease		Migraines	
Asthma		Hyperactivity		Stomach Ulcers	
Autism		Hypoglycemia		Thyroid Problems	
Depression		Panic Attacks		Skin Problems	
Anxiety Attacks		Obsessive/Compulsive		Other:	

Is There a History of Any of the Following in Your Family:

	PAR ENT	SIBL ING		PAR ENT	SIBL ING		PAR ENT	SIBL ING
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					

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

Employment:

- Employed and Satisfied
- Employed but Dissatisfied
- Unemployed
- Coworker Conflicts
- Supervisor Conflict
- Unstable Work History
- Retired

Financial Situation

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

Military History:

- Never in Military
- Military Service – No Combat
- Military Service – combat

Education:

- Did Not Complete High School
- Completed High School

- GED
- Years of College _____
- College Degree: _____