

Adult Intake Form

Today's Date: _____

Full Name: _____ Date of Birth: _____ Age: _____

Address: _____ Zip: _____

Telephone: (H) _____ (W) _____ (Cell) _____

Education (Last grade completed) _____ Degree Earned: _____

Occupation: _____

Marital Status: _____ Years of Marriage (most recent): _____ Spouse's name: _____

Children's names & ages: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Insurance Information (Please complete the following if you intend to file for insurance):

1. Insured's I.D. number as shown on Insurance Card: _____

2. Insured's Full Name (if same as client, skip to item # 4): _____

Insured's Date of Birth: _____ Patient Relationship to Policy holder: _____

3. Insured's Address: _____

4. Insured's employer: _____

Employer's address: _____

5. Insured's Insurance Plan Name: _____ Group #: _____

Insurance Claim Address: _____

Phone #: _____ Ext. _____

6. I authorize the release of medical or any other information to process insurance claims regarding service provided by John C. Palmer, LCSW

Signature: _____

7. I authorize payment of medical benefits to John C. Palmer, LCSW

Signature: _____

Health History

1. Briefly describe your reasons for seeking treatment: _____

2. When did the problem begin and what motivated you to seek treatment now? _____

3. What have you done thus far to improve or alleviate the problem? _____

4. List all past or present mental health treatment:

Dates	Type of treatment	Therapists Name	Where

5. List all current medications: _____

6. List all past psychiatric medications you have taken: _____

7. List any non-prescription drugs (e.g., alcohol, marijuana, cocaine) you currently or periodically use:

8. Please place an "X" for any of the following that have ever applied to you:

Medical	Psychological	
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Juvenile delinquency	<input type="checkbox"/> Family problems
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> School phobia	<input type="checkbox"/> Work problems
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> ADHD/hyperactivity	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Running away	<input type="checkbox"/> Binge/compulsive eating
<input type="checkbox"/> Lung problems (e.g., asthma)	<input type="checkbox"/> Truancy	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Incest
<input type="checkbox"/> Cancer	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Rape
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Childhood fears	<input type="checkbox"/> Sexual identity problems
<input type="checkbox"/> Head injury	<input type="checkbox"/> Learning disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> AIDS or HIV+	<input type="checkbox"/> Teenage pregnancy	<input type="checkbox"/> Other _____