

ABHS INTAKE DATA FORM

Today's Date: _____

1) Personal Identification Information

Client's Name: _____ Sex: M / F Age: _____

Date of Birth: ___/___/___ Social Security Number: _____

Marital Status:

Single / Married / Single in Committed Relationship / Separated / Divorced / Widowed

Address: _____ City/State/ZIP: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-mail Address: _____

What is the best way to contact you? _____

Is it okay to leave a message if you are not available? _____

Employer's Name and Address: _____

Emergency contact person: _____ Relationship to you: _____

Phone number of emergency contact: _____

Who Referred you to this agency? _____

2) Parent / Legal Guardian Information

Please complete this section only if you are under the age of 18 years.

Name(s) of Parent(s) / Guardian(s): _____

Relationship to you: _____

Address: _____ City/State/ZIP: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer(s): _____

3) Spouse / Partner

Please complete this section only if you are married or in a committed relationship.

Name of Spouse / Partner: _____ Date of Birth: ___/___/___

Address (if different from yours): _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Employer(s): _____

4) Insurance Information

Primary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____ Effective Date: ___/___/___

Insured's Name: _____ DOB: ___/___/___ SSN: _____ - _____ - _____

Insured's Address: _____ Insured's Phone: _____

Secondary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____ Effective Date: ___/___/___

Insured's Name: _____ DOB: ___/___/___ SSN: _____ - _____ - _____

Insured's Address: _____ Insured's Phone: _____

Person Responsible for Payment: _____

(Please note that payment may be made by check or cash only; credit cards are not accepted.)

5) Family Data

<u>Relative</u>	<u>Living?</u>	<u>Age</u>	<u>Sex</u>
Male Parent	Yes / No	___	Male
Female Parent	Yes / No	___	Female
Your Sibling	Yes / No	___	M / F
Your Sibling	Yes / No	___	M / F
Your Sibling	Yes / No	___	M / F
Your Sibling	Yes / No	___	M / F
Your Child	Yes / No	___	M / F
Your Child	Yes / No	___	M / F
Your Child	Yes / No	___	M / F
Your Child	Yes / No	___	M / F

6) Health Information

Name of Primary Care Physician: _____ Phone: _____

Office Address: _____

Name of Psychiatrist: _____ Phone: _____

Office Address: _____

Medications:

Name	Dosage	Date Began	Who Prescribed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you rate your present health? Excellent / Good / Fair / Poor

When did you last visit a physician, and why? _____

Please list any current physical symptoms or illnesses: _____

Please check if you or anyone in your immediate family (parents, siblings, children) has had any of the following conditions:

	Self	Family		Self	Family
Alcoholism	___	___	Seizures	___	___
Arthritis	___	___	Anorexia/Bulimia	___	___
Cancer	___	___	Sexual Abuse/Incest	___	___
Cirrhosis of the Liver	___	___	Physical Abuse	___	___
Diabetes	___	___	Physical Disability	___	___
Drug Abuse	___	___	Developmental Disability	___	___
Hepatitis	___	___	Allergies	___	___
High Blood Pressure	___	___	Asthma	___	___
Multiple Sclerosis	___	___	Blood Problems	___	___
Psychiatric Hospitalization	___	___	Heart Disease	___	___
Depression	___	___	Anxiety	___	___
			Other (Please specify)		

(6—Health Information, Continued)

How much alcohol do you typically drink in the course of a week? _____

How often do you use other, “recreational” drugs (for example, marijuana, cocaine, etc.)?

Has alcohol or other drug use ever caused financial, social, legal, medical, emotional, or other problems for you? Yes / No

If “yes,” when was that? _____

Do you smoke cigarettes? Yes / No If “yes,” how many per day? _____

If “no,” have you smoked cigarettes regularly in the past? Yes / No

How many times do you exercise per week, on average? 0 1-2 3-4 > 4 times

Are you on any kind of special diet? Yes / No

If “yes,” please describe: _____

7) Problem Checklist

Please indicate which issues are problematic for you at this time by circling a number.

<u>Type of Problem</u>	<u>Not a Problem</u>	<u>Minor Problem</u>	<u>Important Problem</u>	<u>Most Important</u>
1. Problems between husband/wife, romantic partners	1	2	3	4
2. Family problems, parenting problems, children’s behavior, problems with parents, brothers, sisters	1	2	3	4
3. Problems with social skills, social life, finding friends, getting along with others	1	2	3	4
4. Trouble coping with emotions such as anger, depression, anxiety, stress, withdrawal, etc.	1	2	3	4
5. Problems with sexual functioning	1	2	3	4
6. Problems with alcohol, drugs, food, or gambling	1	2	3	4
7. Legal problems, such as divorce, custody, arrests	1	2	3	4
8. Unwed parenthood, concerns about pregnancy	1	2	3	4
9. Home management, care of the house & family members	1	2	3	4
10. Health concerns	1	2	3	4
11. Money and budgeting problems	1	2	3	4
12. Job or school related problems, such as job dissatisfaction, poor performance, unemployment	1	2	3	4
13. Domestic violence, physical/sexual abuse (past or current)	1	2	3	4
14. Other: _____	1	2	3	4
15. Other: _____	1	2	3	4

8) Degree of Distress/Disruption, & Treatment Expectations

Overall, to what degree are your current concerns disrupting your daily life? (Please check one.)

- I feel immobilized much of the time; it is very hard to cope.
- My concerns affect me a great deal; they bother me much or most of the time.
- They affect me to a considerable degree; they interfere with my performance.
- They affect me to some degree; they bother me somewhat.
- These concerns bother me slightly or not at all.

How long do you expect it will take for your needs to be satisfied in treatment? _____

9) Treatment History

Have you ever seen a psychologist or other counselor before for a psychological or emotional issue? Yes / No

If "yes," please list the approximate dates of treatment & the type of treatment you received, for example, "1998-99, saw a counselor & took medication for depression":

Have you ever been hospitalized in an inpatient setting for a psychological or emotional issue? Yes / No

If "yes," when? _____

Have you ever been treated for drug or alcohol abuse or dependence? Yes / No

If "yes," when? _____

Have you ever attempted suicide? Yes / No

If "yes," how and when? _____

10) Strengths, Supports, Leisure

Where do you find support? (Please include friends, family, community involvements, and spiritual connections) _____

What do you do in your spare time? (Please include hobbies and other interests) _____

How much education have you completed? _____

What are your personal strengths? _____

