ABHS INTAKE DATA FORM

Today's Date: _____

1) Personal Identification Information

Client's Name: _____ Date of Birth: ___/___/___

Gender Identification: Male / Female / Transgender / Nonbinary

Sexual Orientation (Optional): _____

Marital Status: S / M / Single in Committed R'ship / Separated / Divorced / Widowed

Address: _____ City/State/ZIP: _____

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

E-mail Address: _____

Would you like to receive appointment reminders via email? Yes / No

Are we permitted to contact you via Text Message regarding appointments? Yes / No

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: _____

5) Family Data

Relative	Living?	Age	Sex
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: _____

If you give us permission to contact your Primary Care Physician to coordinate care, please sign your name here:

_____Date:_____

Name of Psychiatrist (or Psychiatric Nurse Practitioner): _____

Phone: _____ Office Address: _____

If you give us permission to contact your Psychiatrist or Psychiatric NP to coordinate care, please sign your name here:

_____Date:_____

Medications:

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

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	___	___	Drug Abuse	___	___
Allergies	___	___	Heart Disease	___	___
Anorexia/Bulimia	___	___	High Blood Pressure	___	___
Anxiety	___	___	Liver Problems	___	___
Arthritis	___	___	Multiple Sclerosis	___	___
Asthma	___	___	Obsessions/Compulsions	___	___
Bipolar Mood Disorder	___	___	Physical Abuse	___	___
Cancer	___	___	Physical Disability	___	___
Depression	___	___	Psychiatric Hospitalization	___	___
Developmental Disability	___	___	Seizures	___	___
Diabetes	___	___	Sexual Abuse	___	___

Other (Please specify): _____

(6—Health Information, Continued)

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:

_____

_____

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) 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 a substance use disorder? Yes / No
If "yes," when? _____

Have you ever attempted suicide? Yes / No
If "yes," how and when? _____

8) Problem Checklist

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

Type of Problem	Not a Problem	Minor Problem	Important Problem	Most Important
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. Home management, care of the house & family members	1	2	3	4
9. Health concerns	1	2	3	4
10. Money and budgeting problems	1	2	3	4
11. Job or school related problems, such as job dissatisfaction, poor performance, unemployment	1	2	3	4
12. Domestic violence, physical/sexual abuse (past or current)	1	2	3	4
13. Other: _____	1	2	3	4

9) 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? _____

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? _____

_____