DEWANDA GICHEMI, LMSW

Adult Intake Form for ages 18 and up

Client's Full Legal Name: _____ Date of Birth: _____

Who is completing this form? _____ Relationship to Client: _____

Contact Information:

Client's Residence: _____

- OK to send mail to the above address? Yes No *(please circle one)*

Client's Phone Number: (_____)_____ *(please circle one):* Cell Home Work

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Client's Secondary Phone Number: (_____)_____ *(please circle one):* Cell Home Work

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Client's Email Address: _____

- OK to communicate through email? Yes No *(please circle one)*

Emergency Contact Information:

(Living with you?)

Name: _____ Relationship: _____ Yes No

Address: _____

Phone Number: _____ Alternate phone number: _____

Insurance Information:

Primary Insurance ID or Contract#_____ Group #_____

Name of Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

PO Box for claims *(on the back of the card):* _____

Secondary Insurance ID or Contract# _____ Group #_____

Name of Secondary Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

Subscriber's Address: _____

PO Box for claims *(on the back of the card):* _____ _____

What is the primary concern that you would like addressed in counseling? _____

_____

Have you had any mental/behavioral health treatment in the past? If so, when and where? Please explain:

_____

_____

Personal Information:

Please indicate which of the following you have experienced in the last two years with an X or check:

___ Financial difficulties
___ Gambling in excess
___ Loss of job
___ Pregnancy
___ Retirement
___ Motor accident/injury
__ Marriage
__ Moved (relocated home)
__ Gender identity issues
___ Feeling hopeless or worthless
___ Suicidal or self-harm thoughts
___ Suicide attempt(s)
___ Significant weight gain/loss
___ Angry or easily irritable
___ Problems with self-control
__ Divorce
__ Started/restarted college
__ Problems with family relationships
___ Anxiety or panic attacks
___ Avoiding going anywhere
___ Death of a close friend
___ Relationship problems
___ Death in the family
___ Sexual difficulties
__ New medical diagnosis
__ Eating concerns

Race and Ethnicity (optional):

___ American Indian or Alaska Native
___ Asian American or Asian
___ African American
___ European American
___ Hispanic
___ Pacific Islander
___ Two or More Races
___ Other:_____

Education Status:

___ Non High School Graduate
___ High School Graduate
___ Some College
___ Associate's degree
___ Bachelor's degree
___ Master's degree
___ Doctorate degree
___ Other: _____
___ Current Student, If yes: ___ Full Time ___ Part Time Graduation date/year: _____

- What was the degree earned, and when? _____

Employment Status:

___ Full Time (30+ hours)
___ Part Time (less than 30 hours)
___ Volunteer or Internship
___ Stay at home parent
___ Retired
___ Unemployed

Military history? Yes No *(circle one)* If yes, please indicate when, how long, and what branch:

_____

Sexual Orientation/Status (optional): _____

Which gender do you identify with? ___ Female ___ Male __ Other __ Unsure

If other, please specify: _____

Spirituality (optional):

Religious affiliation? Yes No *(circle one)* If yes: _____

Legal History:

Any involvement with the legal system? Yes No *(circle one)* If yes, arrests or pending charges? Yes No *(circle one)*

Current probation or parole? Yes No *(circle one)* Name of Officer: _____

Friend of the Court or CPS involvement? Yes No *(circle one)*

If yes to any of the above questions *(Legal History),* please explain:

_____

_____

_____

Substance Abuse History:

Do you drink alcohol?	☐ Daily use	☐ Occasional Use	☐ None
Do you use tobacco?	☐ Daily use	☐ Occasional Use	☐ None
Do you use drugs?	☐ Daily use	☐ Occasional Use	☐ None

Has alcohol/drug use interfered with family, work, health, or interpersonal life? ☐ Yes ☐ No

If yes, please explain: _____

Have others viewed your use as a problem? ☐ Yes ☐ No

Have you ever tried to cut down on your alcohol or drug use or quit using? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any prior substance abuse treatment? ☐ Yes ☐ No

Family and Personal or Supportive Relationships: **Living with you?** (circle one)

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Trauma History: *(please circle one)* If yes, when? Please include any information you feel is important.

Emotional	Yes	No	_____
Neglect	Yes	No	_____
Physical	Yes	No	_____
Sexual	Yes	No	_____
Verbal	Yes	No	_____

Medical History:

Have you had any medical procedures? Yes No *(circle one)* If yes, please explain: _____

_____

_____

Medical Conditions and Diagnosis:

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

Please list current medications and what they are taken for:

Name of medication, dose (mg, ml, sublingual, etc.), and frequency — What is it intended for?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please attach another page if necessary.

Obstetrical History:

Please list number of the following:

Pregnancies ____ Full-Term____ Pre-Term____ Abortions____ Miscarriages____

Tubal Pregnancies____ Multiples____ Living Children____

Any additional information for your treating provider? _____

_____

_____

_____

_____

Thank you for taking time to complete this form.

Client, Parent or Legal Guardian Signature: _____ Date: _____

Signature of Treating Provider: _____