Aquiline Counseling
Sandy Tudor, MA, LMHC
Adult Client Intake Sheet

Today's Date:_____

Client Name; First_____ Last_____Middle Initial_____

Address_____City_____Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____Email_____

Acceptable Forms of Communication & Leaving Messages: (check those that are acceptable)

Home Phone____ Cell Phone____ Work Phone____ Email____ Texting____

Age____Date of Birth_____

Emergency Contact: Name_____Relationship_____Phone_____

Please note: Answers are meant to be brief. You can expand on them during your appointment. Anything you are uncomfortable writing down need not be included on this form but can be discussed in person.

Personal and Family History:

Relationship Status: Single____ Married____ Separated____ Divorced____ Widowed____ Cohabitating____

Length of current marriage/relationship_____ Number of divorces_____

Number of previous cohabitations_____ If divorced, for how long?_____

Separations_____ Affairs_____

Other/Comments_____

Children:

1. Name, age,gender_____
2. Name, age, gender_____
3. Name, age, gender_____
4. Name, age, gender_____

Additional/Comments_____

Ours_____ Hers_____ His_____ Biological_____ Adopted_____

Number of Pregnancies_____

Who do you live with?_____

Pets?_____

Please indicate your major life stressors in the past 12 months or so:

Death of a family member or close friend_____ Divorce/Separation_____ Job Issue_____

Serious personal illness or injury_____ Major illness or injury in family_____ Gain of new family member_____

Move____ Financial____ Other_____

Please indicate any of the following you have experienced?

Death of Mother____ Your age at occurrence_____

Death of Father____ Your age at occurrence_____

Death of Child_____ Your age at occurrence_____ Child's age_____

Death of Sibling____ Your age at occurrence_____ Siblings age____

Desertion by Mother_____ Your age at occurrence_____

Desertion by Father_____ Your age at occurrence_____

Divorce of Parents_____ Your age at occurrence_____

Separation of Parents_____ Your age at occurrence_____

Have you experienced: Sexual abuse____ Emotional abuse_____ Physical abuse_____

Neglect_____ Violence in the family_____ Mental illness of a family member_____

Other trauma_____

Treatment Information:

Have you ever received psychological or psychiatric counseling in the past? Yes____ No____

When?_____

From Whom?_____

Purpose_____

Your opinion of results_____

Have you ever been diagnosed with a mental health issue? Yes_____ No_____

What was the diagnosis?_____

Have you ever been prescribed medication for a psychiatric or emotional concern? Yes_____ No_____

When?_____

Name of medication?_____

What were the results of the medication?_____

Are you currently taking psychotropic medication (such as an antidepressant, anti-anxiety medication)? Yes____No____

Name and dosage of the medication_____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes____ No____

Have you ever been in a drug or alcohol treatment program? Yes____ No____ Inpatient____ Outpatient____

Where?_____

Outcome?_____

Medical Information

Primary Care Physician or Clinic_____ Phone_____

Date of latest physical exam_____ Major surgeries_____

Chronic Illnesses_____

Injuries_____

Other pertinent medical_____

Other Current Medications (Name, dosage, frequency)_____

_____

How would you describe your overall health: poor___ fair___ good____ excellent____

Do you use tobacco products?: yes___ no___ What type? cigarettes_____ chewing tobacco _____ pipes_____

cigars_____other_____

How much_____ Use in the past?: yes____ no____

Do you use marijuana products?: yes____ no_____ How much_____Use in the past?: yes____ no____

Do you consume alcohol? yes____ no____

Frequency: Less than once a month____ once a month____ once a week____ once a day_____

Several a day_____ how many?_____ binge drinking_____ black-outs_____

Beer____ Wine____ Hard Liquor_____ Other info on alcohol_____

Do you use any street drugs, misuse prescription drugs or use anything else to get high? Yes____ No____

Name of drug(s) and frequency_____

_____

Do you have any compulsive/addictive behaviors? yes___ no___

gambling_____ sex_____shopping_____ gaming_____internet_____other_____

Employment/Education background

Your current employment status: Full time____ Part time____ Hours per week_____ Unemployed_____

Stay at home by choice_____ Disabled_____ Type of Disability_____

Current position / Job title _____Employer _____

How long at current job?_____

How long unemployed or disabled_____

How many jobs have you had in the last 5 years?_____

How satisfied are you with your current job? Not satisfied____Somewhat satisfied___ Comfortable___Very satisfied___

Career goals_____

Education: Did not finish high school____ High School Diploma____ GED____ Some college____

College Degree_____

Spiritual Resources

How important is spirituality in your life? Not important___ Somewhat important___ Significant___ Very significant___

Optional: Religious affiliation / faith / beliefs / denomination _____

Please describe the main concern(s) that have prompted you to seek counseling: _____

_____

_____

_____

_____

_____

What changes would you like to make in your life? _____

_____

_____

_____

What are your goals for counseling? _____

_____

_____

_____

Insurance Information

Note: Clients are financially responsible for annual deductibles, co-insurance and/or co-pays not covered by insurance.

Insurance Company _____ Phone _____

(a copy of insurance card and personal identification required at time of first visit)

Client relationship to policy holder: Self___ Spouse ____ Child ____ Other ____

Policy ID number _____ Group number _____

Name of Policy Holder _____Date of Birth of Policy Holder_____

Address if different than client _____Phone_____

Employer_____

Is there any other health benefit plan? Yes ___ No____

I agree to permit ***Sandy Tudor and Aquiline Counseling LLC*** *to release to my insurance company and/or their representatives any information necessary for processing my insurance claims. This information may include: personal information listed above, diagnosis, dates of office visits, types of service, and the amount of charge. My signature also indicates that the information I have provided is true and complete. I understand that failure to provide complete information will result in my being held personally responsible for all charges incurred****. I understand that I am held financially responsible for unreimbursed charges not covered by the insurance policy.***

Cash Paying Client: I understand that payment is due at the time services are rendered.

Client Signature_____**Date**_____