RIVER VALLEY COUNSELING, LLC

ADULT INTAKE PACKET

Counselor seeing:_________________________

CLIENT INFORMATION

Client Name ____

Street Address ____ PO Box _______________________

City/State/Zip ____

Home Phone # ______________________ **May we call or leave a message at this number?** ❑ Yes ❑No

Daytime Phone # ____________________ **May we contact you here?** ❑Yes ❑ No

Cell Phone # ________________________ **May we call or leave a message on this phone?** ❑Yes ❑No

Client Date of Birth ___________________ Age: _____ Social Security # ____________________________

Parent/Responsible Party Name (if client is minor) _________________________ _________________________

Parent/Responsible Party Social Security # ____________________________ Date of Birth____________________

Primary Care Physician ____

Emergency Contact Name (required_________________________________ **Phone #**:____________________

Address (required):____

Insurance Information **(Copy of Insurance Card and Driver's License is Required)**

• This section is required to be filled out in full •

1) <u>Primary</u> Insurance Company ____________________________ Ins. Co Phone # _______________________

Employer of Subscriber ____

Name of Subscriber ____ Date of Birth __________________

Address of Subscriber (if different from Client) ____

Subscribers Social Security # ___________________________ Relationship to Client___________________

2) <u>Secondary</u> Insurance Company ___________________________ Ins. Co Phone # _______________________

Employer Name (with address) ____

Name of Subscriber ____ Date of Birth __________________

Address of Subscriber (if different from Client) ____

Subscribers Social Security # ______________________________ Relationship to Client ___________________

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT AGREEMENT

<u>The above information is current and correct to the best of my knowledge</u>.

I understand the terms of my insurance coverage noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to RVC to release such information as may be necessary for completion of any insurance claim with payment of benefits to RVC for services rendered.

_____________________________ _____________________________ ____________________

Client Name (please print) Client Signature Date

_____________________________ _____________________________

Witness Date

RIVER VALLEY COUNSELING, LLC

131 North Ewing Street, Suite B
Lancaster, OH 43130-3383

Client Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Identifying Information

Name:______________________________________ **Date of Birth:** ________________ **Age:**_______________

Gender: ❑ Male ❑Female **Race:** _____________ **Height:** ______________________ **Weight:**____________

Hair Color:______________ **Eye Color:** ________________

Behavioral Health

Why are you seeking to counseling?

What issues or circumstances do you believe contribute to your problems?

How long has this problem persisted? ___________

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Have you previously been involved in counseling? ❑No ❑ Yes **If yes, describe the reasons for counseling, who provided the counseling, and the outcome.**

Counselor ____________________________

Reason:

Outcome:

List your greatest strengths:

List your greatest weaknesses:

Psychiatric Hospitalizations: ❑**None** ❑**Past** ❑**Current**

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)

Drug and Alcohol History

CLIENT NAME: ____ DOB: ____/____/____

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	❑	❑	❑	**Hallucinogens**	❑	❑	❑
Marijuana	❑	❑	❑	**Inhalants**	❑	❑	❑
Hashish	❑	❑	❑	**Cocaine**	❑	❑	❑
Stimulants	❑	❑	❑	**Heroin**	❑	❑	❑
Sedatives	❑	❑	❑	**Other**: ______________	❑	❑	❑

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection

Are you currently pregnant? ❑ No ❑ Yes **Are you an IV drug user?** ❑ No ❑ Yes

Have you ever received inpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? ________________________ Where? ____________________________

Have you ever received outpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? ________________________ Where? ____________________________

Are you involved in any community self-help groups such as AA ❑ No ❑Yes

Family History

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
❑ Living with a Significant Other but Never Married

If married: how long have you been married? _________ Spouse's age: __________

Are you presently experiencing any serious marital conflicts?

❑ No ❑ Yes If yes, explain:____

If you have ever been divorced: How many times were you previously married? _______

Date of divorce(s) ____

Prior to the divorce(s), how long were you married? ____

Reasons for divorce(s)____

____

Living Situation: ❑Own Home ❑ Parent's Home ❑ Relative's Home ❑Homeless ❑Group Home
❑Residential ❑ Other ____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education

Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Medical History

CLIENT NAME: ____ **DOB:** ____/____/____

Physician Name: __❑ No ❑ Yes ____ **Phone:** ______________________________

Address: ____
Street & Number City State Zip

Date of most recent physical exam: ______________ **By Whom:** ____________________

Results: ____

Immunizations - Check the immunizations for the following diseases: ❑ Chicken Pox ❑Diphtheria ❑ German Measles ❑Measles ❑Mumps❑Polio ❑ Small Pox ❑Tetanus

Drug Allergies:

List any major illness and/or operations

Have you had any medical hospitalizations in the last three years ❑ No ❑ Yes, if yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Have you ever had head trauma that resulted in loss of consciousness and/or required medical treatment? ❑ No ❑ Yes

What medications is are you now taking? *List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.*

Prescription/Over the Counter Medication: ❑No ❑ Yes	**Out of Medication:** ❑ No ❑ Yes
Current Medication: __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** __________________ **Total Daily Dosage:** ___________ **Reason:** ____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

Do you think these medications help you get better? ❑ N/A ❑ No ❑ Yes ❑ Unknown

Do you use caffeine? ❑ No ❑ Yes from (coffee, tea, soda)__________________ Daily Use___________
Do you use tobacco? ❑ No ❑ Yes from (cigarettes, snuff, snus) ________________ Daily Use___________

Describe your appetite? ❑ Poor Appetite ❑Average Appetite ❑Large Appetite
Has your weight changed in the last year? ❑ No ❑Yes If yes, by how much? _________ **❑ weight gain ❑loss**

How much sleep do you get each night? _______________ **When you go to bed, how long does it take you to fall asleep?**_________
Do you awaken in the night and have difficulty returning to sleep? ❑ No ❑ Yes **Do you awaken before you plan to get up?** ❑ No ❑ Yes

Has client had any of the following symptoms in the past 60 days? ***Please check.***

❑ Bedwetting ❑Coughing ❑Lightheadedness ❑Sleep Problems
❑ Blood in Stool ❑Diarrhea ❑Memory Problems ❑Seizures
❑ Breathing Difficulty ❑Dizziness ❑Muscle Weakness ❑Tingling in Arms/Leg
❑ Confusion ❑Falling ❑Nervousness ❑Tremors
❑Consciousness Loss ❑Gait Unsteadiness ❑Panic Attacks ❑ Vision Changes
❑Constipation ❑Hearing Loss ❑Pulse Irregularity ❑ Vomiting
❑ Other: ____________________________________

CLIENT NAME: ______________________________________ **DOB:** ____/____/____

Educational History

Highest Degree attained: ❑ High School ❑Associate Degree/2yr tech ❑Bachelor's Degree ❑Master's Degree ❑Ph.D.

Highest Academic Year completed:_____ **Highest Vocational Year Completed: (if applicable)**______

Type of school placement: ❑ Regular ❑ Special Education ❑Home-Schooled ❑Unknown

Type of Special Education Placement: ❑ None ❑Cognitive Disability ❑Emotional Disability ❑Learning Disability ❑Multiple Disabilities ❑Other: ____

Did you have difficulties in school? ❑ No ❑ Yes. If yes, please explain

Do you have special communication needs? ❑ TTD Device ❑Interpreter Services

Employment History

Employment Status

❑Employed Full Time (30 or more hours) ❑ Employed Part Time If part time, number of hours worked weekly _______

Job/Occupation:________________________________

❑Unemployed ❑Unemployed due to disability. Date Last Worked________________

If unemployed, do you want to work? ❑No ❑Yes. If yes, what kind of work would you like to do?___________________________

Current Employment

Name of employer: ________________________

Job Position:_________________________ How long have you been in this position __________

Date Last Worked________________

Have you been disciplined by your supervisor? ❑Yes ❑No
Have you had frequent tardiness? ❑Yes ❑No
Have you had frequent absences? ❑Yes ❑No
Are you satisfied with your job ❑Yes ❑No
Financial Problems ❑ No ❑Yes If yes, explain: ____

Military History

Are you currently in the military? ❑ No ❑Yes If yes, what branch? _______________________ How long? _________________

Rank:___________________ What work did you do for the military?____

Have you recently been deployed to a combat zone? ❑ No ❑Yes If yes, have you experienced any psychological or physical difficulties because of this deployment? ❑ No ❑Yes explain?____

Have you ever been in the military? ❑ No ❑Yes If yes, what branch? _______________________ How long? ______________

Rank:___________________ What work did you do for the military?____

When were you discharged?________________________ Type of discharge:____

Have you ever been deployed to a combat zone? ❑ No ❑Yes If yes, when?__________ Have you experienced any psychological or physical difficulties because of this deployment? ❑ No ❑Yes explain?____

Interests and Community Involvement
What meaningful activities, including leisure and recreational activities to you engage in?
What community activities, including volunteer work are you involved in?
What religious or spiritual activities do you participate in?
List any cultural or family traditions you have?

Legal History
Do you have a Legal Guardian/Custodian? ❑ No ❑Yes If yes, Name: ___________________________________Phone:________________
Civil Proceedings:____ ❑ Current ❑ Past When? ____________
Domestic Relations Court **(Custody, Protective Services, Restraining Orders):** _____________________________________ ❑ Current ❑ Past When? ________
Child Support Enforcement Orders:____
Job and Family Service Involvement with Family:____ **Caseworker assigned to Family:**___________________________________**Phone:**________________________
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency): ❑ Current ❑ Past When? ____________
Current Legal Status: ❑ **None** ❑ **Awaiting Charges** ❑ **On Probation/Parole** ❑ **Conditional Release** ❑ **Outpatient Commitment** ❑ **Incarcerated** ❑ **Other:** ____
Legal Charges: Juvenile ❑ No ❑Yes If yes, ❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________ ❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________
Legal Charges: Adult ❑ No ❑Yes If yes, ❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________ ❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ___________
Incarcerations: **From** ________ **To** _________ **Where**___________________________ **Conviction:**__________________________ **From**________ **To** _________ **Where**____________________________ **Conviction:**__________________________
Probation/Parole Officer: ____ **Phone:** ___________________________

Print Name (Person completing questionnaire):	**Signature:**	**Date:**
Reviewer Name/Degree (if applicable)	**Signature:**	**Date:**
Comments:		

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart kept at River Valley Counseling, LLC, may not be released to anyone without my written consent, with the exceptions listed in the Notice of Privacy Practices form and/or the Consent for Treatment and Information Sheet.

CLIENT'S SIGNATURE ____ **DATE** ____________________________
PLEASE PRINT LAST NAME ___________________________________ **FIRST NAME** ______________________