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) Primary 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) Secondary 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

The above information is current and correct to the best of my knowledge.

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

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:** _____

Behavioral Health

Why are you seeking to counseling?

How long has this problem persisted? _____

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:**_____

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

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

Drug and Alcohol History

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
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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: _____

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

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**

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

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

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?**_____

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

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

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_____
Current Employment
Name of employer: _____
Job Position:_____ How long have you been in this position _____
Date Last Worked_____

Military History
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 religious or spiritual activities do you participate in?

Legal History
Domestic Relations Court (Custody, Protective Services, Restraining Orders): _____ ❑ Current ❑ Past When? _____
Job and Family Service Involvement with Family:_____
Caseworker assigned to Family:_____ **Phone:**_____
Current Legal Status: ❑ None ❑ Awaiting Charges ❑ On Probation/Parole ❑ Conditional Release ❑ Outpatient Commitment ❑ Incarcerated ❑ Other: _____
Probation/Parole Officer: _____ **Phone:** _____

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** _____