

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

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

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

Primary Care Physician _____

Emergency Contact Name (required) _____ **Phone #:** _____

Emergency Contact Name (required): _____ **Phone #:** _____

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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe the reasons for counseling, who provided the counseling, and the outcome. Counselor _____ Reason: _____ Outcome: _____	
Psychiatric Hospitalizations: <input type="checkbox"/> None <input type="checkbox"/> Past <input type="checkbox"/> Current	
Dates of Service: _____	# of Days _____
Where & Reason (suicidal, depressed etc.) _____	

Drug and Alcohol History					
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Family History						
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> 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: <input type="checkbox"/> Own Home <input type="checkbox"/> Parent's Home <input type="checkbox"/> Relative's Home <input type="checkbox"/> Homeless <input type="checkbox"/> Group Home <input type="checkbox"/> Residential <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, complete below:			
Hospital	City	Date	Reason
<i>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.</i>			
Prescription/Over the Counter Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Describe your appetite? <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Average Appetite <input type="checkbox"/> Large Appetite			
Has your weight changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much? _____ <input type="checkbox"/> weight gain <input type="checkbox"/> 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 _____