3700 5th Avenue
Lake Charles, Louisiana 70607
337-429-5129

ADULT INTAKE FORM

Today's date: _____

Patient Information:

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Phone Number: (___)_____ Email Address:_____

Gender M/F Race/Ethnicity (optional): _____

Marital Status: (circle) Married Divorced Separated Widowed

Insurance Information:

Primary Insurance _____ Policy/Group# _____

Policy Holder's Name_____ Policy Holder's Date of Birth_____

Policy Holder's SS#: _____

Secondary Insurance _____ Policy/Group# _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Date of Birth

Emergency Contacts:

Name: _____ Phone: _____
(first) (last)

Name: _____ Phone: _____
(first) (last)

Referral Information:
Who referred you to Resolutions Counseling Services, LLC?

_____
(name) (phone)

_____
(address)

Presenting Problem:

What problem(s) are you seeking counseling for?

_____
_____
_____
_____

How has this problem affected your ability to function at home, school, work and/or in the community? If so, how?

_____
_____
_____
_____
_____
_____

What are your goals/expectations in counseling? _____

Have you recently worried that you have:

☐ Yes ☐ No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)

☐ Yes ☐ No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, to talkative, inappropriate sexual behaviors, grandiose, etc.)

☐ Yes ☐ No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and or compulsive behaviors, frequent complaining of headaches and or stomach aches, frequent school absences, etc.)

☐ Yes ☐ No BEHAVIORAL PROBLEMS (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

☐ Yes ☐ No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

☐ Yes ☐ No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

☐ Yes ☐ No SOCIAL ANXIETY (shy and/or afraid to be around others)

☐ Yes ☐ No POST TRAUMATIC STRESS (frequent nightmares, intrusive and/or recurrent memories, remembering past traumas, etc.)

☐ Yes ☐ No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

☐ Yes ☐ No DISSOCIATION (feeling outside your body or things are not real, etc.)

☐ Yes ☐ No Have you ever harmed yourself intentionally? If so, how_____

_____

☐ Yes ☐ No Intentionally harmed others? If so, how? _____

_____

Past Psychiatric History:
Please list any previous psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs)

Reason for Stay | Length of Stay | Facility

Please list any current or prior mental health providers (Psychiatrist, Psychologist, Counselor, Social Work, Psychiatric Nurse) you are seeing or have seen?

Provider Name | Title | Location | How Long?

Please list your current mental health medications.

Name | Dosage | Duration | Response

Drug Use History:

Substance	Date of Last Use	Problems Related to Use	Treatment Required
Prescription Drugs (Vicodin, OxyContin, Xanax, Lortabs, Percocet)		☐ Yes ☐ No	☐ Yes ☐ No
Marijuana		☐ Yes ☐ No	☐ Yes ☐ No
Cocaine		☐ Yes ☐ No	☐ Yes ☐ No
Designer Drugs (Club Drugs: G, X)		☐ Yes ☐ No	☐ Yes ☐ No
Hallucinogens (LSD, Mushrooms, PCP)		☐ Yes ☐ No	☐ Yes ☐ No
Inhalants (Gasoline, Glue, Aerosol)		☐ Yes ☐ No	☐ Yes ☐ No
Methamphetamines (Speed, Ice, Crank)		☐ Yes ☐ No	☐ Yes ☐ No
OTC – Over the counter (Benadryl, Nyquil, Dramamine)		☐ Yes ☐ No	☐ Yes ☐ No

Is there anything else we should know about any drug history?

Is there anything else we should know about your psychiatric history?

Family Mental Health History:

Review the list below – if any immediate family member has one of these disorders, check the disorder and describe their relation to you (such as "Maternal Uncle") and their treatment history (if applicable). Consider immediate family as parents, brothers, sisters, grandparents, aunt, uncles and 1st cousins.

_____ Depression_____
_____ Anxiety_____
_____ ADHD_____
_____ Bipolar (manic depressive)_____
_____ Schizophrenia_____
_____ Learning Disabilities_____
_____ Autism/Asperger/Pervasive Developmental Disorder_____
_____ Mental Retardation_____
_____ "Nervous Breakdown"_____
_____ Psychiatric Hospitalizations_____
_____ Suicide (or attempts)_____
_____ Panic Disorder_____
_____ PTSD (Post Traumatic Stress Disorder)_____
_____ OCD (Obsessive Compulsive Disorder)_____

Medical History:

Primary Care Provider: _____ Years Involvement: _____
Phone: _____
Address: _____
Approximate Date of Last Visit: _____
Approximate Number of Visits in Last Year: _____

Do you have any chronic medical problems? ☐ Yes ☐ No If yes, please describe: _____
_____
_____
_____

Do you have a history of any serious injuries or medical hospitalizations? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Abuse History:
Has you ever been the victim of abuse or neglect? ☐ Yes ☐ No
If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing violence	Other: _____	

_____
_____
_____
_____
_____
_____

Are you struggling with your marriage, relationship and/or or parenting? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____