Ron Leonard, Professional Clinical Counselor
Intake Form

Date: ____________________ Referred by: _____________________

Clinical Information

Name: ____ Sex: ____

Address: ____

City: ________________________________ State: ____ Zip Code: __________

Home Phone: _______________ Cell Phone: ____________

Work Phone: _______________ Work Hours: ___________

Please indicate any phone #(s) it is NOT OK to leave a message on: _______________

Date of Birth: ___________ Card Holder Date of Birth: _________________________

Type of Insurance: ___________________ ID or Policy #_____________________

Group #: __________________ Provider Phone # on back of card: _______________

I hereby authorize the release of necessary information for the purposes obtaining payment for treatment AND I accept financial responsibility for all charges made to me, whether or not they are covered by insurance.

Signature: ____
Date: _____________

Guardian Information

Name: ____

Address (if same leave blank): ____

City: ________________________________ State: ____ Zip Code: __________

Non-Custodial Parent

Name: ____

Address (if same leave blank): ____

City: _______________________________ State: ____ Zip Code: __________

If split custody, please explain: ____

____

Emergency Contact

Name: ____

Address (if same leave blank): ____

City: _______________________________ State: ____ Zip Code: __________

Home Phone: _______________ Cell Phone: ____________

Relationship to Client: ______________________________

Client Information:

Marital Status: ______________________ Highest Grade Completed: ____________

Living arrangement (i.e. own home, lives w/ parents, nursing home, etc): _____________

____

List All Person Living in the Client Home

Names (First)	Relationship to Client	Age
_____________________	____________________	_____________
_____________________	____________________	_____________
_____________________	____________________	_____________
_____________________	____________________	_____________
_____________________	____________________	_____________

Employment Status (full, part, unemployed): __________________________________

Company Name: ________________ Position: _______________ Yrs worked: ____

Health Assessment: Diagnostic Assessment—Self Report

Health History

Has there been any problem in your general physical health within the past 5 years?
Explain. ____

Date of last medical checkup: ______________________________

Are you under a physician's care now? _____ If yes, for what reason? ________
____

Physician: _________________________________ Phone # ________________

List any medications you may have taken over the last 4 months:

Medicine	Dosage in mg	How Often	Prescribing M.D.
________________________	___________	__________	________________
________________________	___________	__________	________________
________________________	___________	__________	________________
________________________	___________	__________	________________
________________________	___________	__________	________________
________________________	___________	__________	________________

Are you allergic to any food, drugs, medications, etc. _________ If yes, please list:

____
____

Do you have or have you had any of the following diseases or problems?

	Y	N
Head Injury	Y	N
Fainting Spells, loss of consciousness	Y	N
Rheumatic Fever, Rheumatic heart disease	Y	N
High Blood Pressure	Y	N
Seizures, Epilepsy	Y	N
Panic/Anxiety Attacks	Y	N
Pain the chest, shortness of breath	Y	N
Asthma, hay fever	Y	N
Hepatitis, jaundice, liver disease	Y	N
Arthritis	Y	N
Dental problems	Y	N
Diabetes	Y	N
Vision problems	Y	N
Underweight	Y	N
Overweight	Y	N
Kidney problems	Y	N
Liver problems	Y	N
Tuberculosis	Y	N
Persistent cough, cough up blood	Y	N
Cutting or other self-harm	Y	N
Chemo/Radiation Treatment	Y	N
Headaches/Migraines	Y	N
Nausea	Y	N
Diarrhea/Abdominal distress	Y	N
Fatigue, loss of energy	Y	N
Insomnia, Sleep Difficulty	Y	N
Distressing, recurrent dreams/Nightmares	Y	N
Sleep more than 10 hours per day	Y	N
Binge Eating	Y	N
Self-induced Vomiting	Y	N
Use of Laxatives	Y	N
Significant weight change in short time	Y	N
Cancer	Y	N
HIV positive/AIDS/Sexually transmitted disease	Y	N
Bedwetting, loss of bladder/bowel control	Y	N
Ulcers	Y	N

Do you have any disease, condition, or problem not listed previously that you think is important to state? ____

____

Do you drink coffee/cola drinks? Y N How much? _______

Do you smoke cigarettes? Y N How many? _______

Do you exercise regularly? Y N

Do you eat 3 regular meals per day? Y N

Do you have any known physical disabilities? Y N

Have you been physically or sexually abused? Y N

Do you have any sexual dysfunction? Y N

Please comment on any of the above: ____

____

Do you drink alcoholic beverages? Y N

If yes, what? ____

How many drinks per week? ____

Have you ever lost time from work due to drinking? Y N

Do you often drink in the morning? Y N

Has your drinking ever caused problems with family,
Friends, the law or your job? Y N

Does any member of your family have a drinking problem? Y N
Who? ______________________________

Have you ever used street drugs? Y N

If yes, what? ________________ Year of 1st use? _______________

Currently using? ___________________ How often? _________________

Date of last use? ___________

Have you ever been in an alcohol/drug treatment program? Y N

If yes, please complete the following:

Name	When	Length of Stay
____________________	____________	____________________
____________________	____________	____________________

Have you used any unprescribed, herbal, or over the counter drugs in the past 4 months?

If yes, please complete the following:

Name	When	Length of Stay
____________________	____________	____________________
____________________	____________	____________________

Have you ever been pregnant? Y N

List when: ____

Any complications with or from your pregnancy including postpartum depression? ____

____

CLIENT BACKGROUND

How good is your Energy Level? ____________________________________

Sleep? ____

Appetite? ____

Do you have Legal issues? ____

What is your Marital History? _____________________________________

CLIENT BACKGROUND (CONT.)

History of physical, sexual, or emotional abuse? ______________________________
____
____

Family History of psych or substance abuse:
____
____
____
____

Past Psychiatric Services

Names	Dates	Length
______________________________	__________________	________________
______________________________	__________________	________________
______________________________	__________________	________________
______________________________	__________________	________________

Suicidality Past & Present: ____

Homicidality: ____

History of Psychosis? ____

History of Self-mutilation? ____

Interests and Hobbies: ____

____

Refusal to Complete Health Assessment Self-Report

I refuse to complete the Health Assessment Self-Report. I understand that this refusal does not interfere with my right to service.

Client: ___________________________ Date: _____________________

Witness: _________________________ Date: _____________________