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: _____ Cardholder 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: _____

Work Phone: _____ Work Hours: _____

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 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?

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

Energy Level? _____

Sleep? _____

Appetite? _____

Legal issues? _____

Marital History? _____

History of physical, sexual, or emotional abuse? _____

_____
_____

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

Past Psychiatric Services

Names	Dates	Length
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Suicidality Past & Present: _____

Homocidality: _____

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: _____