Restored Haven Counseling

9896 Bissonnet St. Ste 455, Houston, TX 77036
Kandys McKinley, MEd, LPC, LSOTP

ADULT CLIENT INTAKE

(Please print clearly & fill in completely)

Note: If you were a patient here before, please fill in only the information that has changed

Today's Date:_____ Referring person or Agency:_____

General Information:

Name:_____Date of Birth____/_____/_____ Age:___ Gender: M F (circle)

List the address and telephone number(s) you wish this office to use to contact you:

_____, _____, _____ _____
Address City State Zip Code

(_____)_____ (_____)_____ (_____)_____
Home Phone Work Phone Mobile Phone

Educational Level:_____ Occupation:_____

Place of Employment_____

Insurance Information*: *Please have copy of insurance card available.

Insurance Carrier: _____Phone number: _____

Subscriber/Member ID Number:_____

Client is one of the following: __Subscriber ___Spouse __Child

Name of the insurance subscriber (primary): _____
DOB:_____ Insurance Authorization #_____

Family of Origin:

Place of birth_____ Where were you raised?_____

How many children in family?_____ What is your birth order?_____

Describe your relationship with your siblings:_____
_____

Describe Relationship with mother and father:_____
_____
Any significant problems with family members:_____
_____

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Marriage and Family:

Marital Status:_____ If divorced, when? _____

Describe your spouse: _____
Marital problems?_____
_____
_____

Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/ widowed	Is spouse remarried
First					
Second					
Third					

Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current Age	Sex	School	Grade	Adjustment Problems	P?

Medical History:

Illness/Accidents	Age	Length of Recovery

Hospitalizations: Date Admitted:_____Reason for admission_____

Date Admitted:_____Reason for admission_____

Current medical concerns:_____
_____

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Current Medications	Dosage	Frequency	Purpose

Mental Health

Have you had prior psychological, psychiatric, counseling, drug or alcohol services?

Yes □
No □

When	Where	Diagnosis	Treatment Provider	Treatment Outcome

Treatment for Chemical Use

Dates		Agency/ Provider	Type of Program*	Voluntary?		Length of treatment	Methods used	Participation in aftercare programs		Effects of treatment‡
From	To			Yes	No			No	Which?	

*** In the fourth column, use these codes: AA/NA = Alcoholics Anonymous/Narcotics Anonymous; O = Outpatient Counseling; ID = Inpatient detoxification; IT = Inpatient treatment (e.g., 28-day); Other:_____**

‡ In the last column, use these codes: W = made situation worse; N = No change; U = better understanding of addiction; R = Reduction of use; BA = Brief abstinence (up to a month); LA = Long-term abstinence (several months or more); O = Other effects: _____

Self-description of use

1. Would you say you: □are a social drinker; □a heavy drinker; □have alcoholism, or □ have a drinking problem? Or how would you describe your use? _____
   _____
   _____

2. Would you say you: □are a recreational drug user; □ have an addiction or; □ have a drug problem? Or how would you describe your use? _____

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_____

_____

Reason for Visit (Presenting Problems)

I. Substance Abuse/Dependence	II. Medical	III. Emotional/ Psychological	IV. Psychological/ Environmental
□ Alcohol □ Drug □ Nicotine □ Another Substance Use/Health Concern □ Other	□ Medical Problem □ Change in weight /Appetite □ Change in sleep □ Medication issues □ Withdrawal from Substance Abuse □ Other	□ Anxiety □ Depression/ Hopelessness □ Other Mood Disorder □ Phobia/ Disturbance of Thought/ Unusual Fears □ Obsessions/ Compulsion □ Gambling/ Impulse Control Disorder □ Eating Disorder □ Psychosis □ Hyperactivity □ Learning Disability □ Sexual & Gender Disorders □ Other	□ Job/Occupation □ Financial □ Legal □ Childcare □ Elder Care □ Career/Retirement Planning □ Disability □ Marital/Family/ Relationship □ Sexual/Physical Trauma □ Grief/Loss □ Health Issue □ Other

Describe current problems or goals for mental health services:

_____
_____
_____
_____

LETHALITY		OVERALL RISK RATING:	HISTORY
□ Suicidal Ideation Yes □ No □ □ *Plan?* □ *Means?* □ Suicidal Intent: Yes □ No □ □ *Mild* □ *Moderate* □ *Severe*	□ Homicidal Ideas Yes □ No □ □ *Plan?* □ *Means?* □ Homicidal Intent: Yes □ No □ □ *Mild* □ *Moderate* □ *Severe*	□ Mild, Moderate □ Serious (Urgent) □ High risk (non-life threatening) □ Extreme emergency (life-threatening)	□ History of MH □ Family History of MH