New Beginnings
HEALTH AND WELLNESS

ADULT INTAKE

Name: _____
DOB: _____
Chart #: _____
MID/Ins #: _____
MID/Ins #: _____

CLIENT INFORMATION

DATE _____

First Name	Middle Name	Last Name		
Address	City	State	Zip	County
Home Phone	Cell Phone	Work Phone		
Date of Birth / Age	Sex: ☐ Male Female Other	Preferred Language:		
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian Pacific Islander ☐ White ☐ Decline to report		Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to report		

INSURANCE INFORMATION (Copy of Insurance Card/s Required)

Primary Insurance Name:	**Secondary Insurance Name:**
Subscriber Name / Date of Birth	Subscriber Name / Date of Birth
Subscriber's Address	Subscriber's Address
Subscriber's Telephone #	Subscriber's Telephone #
Client's Relationship to Insured ☐ Spouse ☐ Partner ☐ Child ☐ Self	Client's Relationship to Insured ☐ Spouse ☐ Partner ☐ Child ☐ Self
Subscriber ID # / Group ID #	Subscriber ID # / Group ID #

Emergency or imminent risk contact:
Name: _____ Telephone# _____ Relationship:_____

How did you hear about us? ___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

Crossroads offers appointment reminders. Check below all the ways you wish to receive a reminder.

☐ To Be Called Telephone Number _____
☐ Text Message Text Number _____
☐ Emailed Email Address _____

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Individuals participatinginassessment: _____

Employment/Education

Employment Status ___Employed ___ At-Home Parent ___ Student
___Unemployed ___ Disabled ___ Military

Employer _____ ___ Full-Time ___ Part-Time
Job Title / Occupation _____

Highest level of education completed _____
If student, list school _____
Course of study _____

Household Information

Current status of significant relationship:
___ Single ___ Separated ___ Living together ___ Dating ___ Other
___ Married ___ Divorced ___ Life partner ___ Widowed

List all members of your household:

Name	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who were you raised by? _____
List significant family relationships who do not live with you (parents, siblings, close grandparents, caregivers, etc.)

Name	Relationship	Still living?
_____	_____	___ Yes ___ No
_____	_____	___ Yes ___ No

Social Information

Spiritual preference: _____
List any support systems: _____
Hobbies and community activities: _____

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Medical History Have you experienced any of the following? (If yes, explain.)

___ Childhood trauma _____
___ Adult trauma _____
___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
___ Significant family medical history _____
___ Significant family mental health history _____
___ Significant family substance history _____
___ Priormental health diagnosis _____
___ Priordevelopmental diagnosis _____

Primarycare physician _____

Currentmedications Name Dosage

_____ _____
_____
_____
_____

PharmacyName _____ Telephone # _____
Address _____

Substance UseHistory

Alcohol _____
Illegal Drugs _____
Prescription Drugs _____
Smoking ☐ Non-Smoker Current Smoker Ex-Smoker Smokeless Tobacco
Other _____

Legal Involvement

List any charges/arrests/convictions: _____
_____

Mental Health Treatment History

Listallmentalhealth treatment,substance abuse treatment or hospitalizations

Facility/Therapist	Purpose	Current	Past

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Response to Treatment: _____

Other agency services/relationships in the last six months:

___ Child Protective Services
___ Other DSS Services
___ Occupational Therapy
___ Justice System
___ Disability/Social Security
___ Speech therapy
___ Outpatient Mental Health
___ Outpatient Substance Abuse
___ Other: _____

Current Treatment Focus

What brings you to our office today? _____

_____

_____

_____

What services are you seeking?

___ Individual Therapy
___ Family Therapy
___ Couples Therapy
___ Psychological/Educational Testing
___ Psychiatric Services or Medication Management
___Other (explain): _____

I/we would like to address the following: (check all that apply)

___ My mood or emotional state (depression, anxiety, anger, etc.)
___ My behavior / choices
___ My cognitive / mental functioning
___ School / academic performance
___ Parenting
___ Abuse, neglect, or trauma history
___ Adjustment to new cultural
___ Sleep, eating, or physical concerns
___ Relationships with family or peers
___ Divorce
___ Grief / Loss
___ Workplace issues
___ Other: _____

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Adult Assessment: Check all the following that currently apply.
Indicate past concerns with the letter "P".

_____ Anxiety
_____ Depressed mood
_____ Panic attacks
_____ Racing thoughts or speech
_____ Obsessions/Compulsions
_____ Excessive fears or phobias
_____ Dissociative states
_____ Touchy/irritable
_____ Nightmares
_____ Sleep problems
_____ Incontinence or bedwetting
_____ Rage or "meltdowns"
_____ Conflicting parenting styles
_____ Parental/marital problems
_____ Adoption/foster care history
_____ Lots of physical complaints
_____ Eating issues
_____ Addictions

_____ Hurts others
_____ Lying
_____ Stealing
_____ Destroying property
_____ Defiance
_____ Blames others for mistakes
_____ Angry/resentful
_____ Lack of conscience
_____ Bizarre behavior
_____ Clingy
_____ Separation anxiety
_____ Seems to overreact
_____ Feels overwhelmed
_____ Argumentative
_____ Life has been unstable _____
Life changes pending
_____ Cultural Adjustments
_____ Loss due to death

_____ Hyperactive
_____ Attention problems
_____ Worries all the time
_____ Impulsive
_____ Low self-esteem
_____ Suicidal thoughts
_____ Suicide attempts
_____ Self-harming
_____ Sexually acting out
_____ Pornography
_____ Difficulty with change
_____ Needs predictability/routine
_____ Unexplainable mood shifts
_____ Running away
_____ Deliberately annoys people
_____ Takes excessive risks
_____ Experienced discrimination
_____ Loss due to other

Use the space below to tell us anything else you would like for us to know in order to best help you:

_____
_____
_____
_____
_____

Icertify that the information provided in this document is correct to the best of my knowledge.

_____ _____
Client Signature **Date**