JAMES FAUST
& ASSOCIATES • PLLC
COUNSELING • COACHING • TRAINING

Client Intake Form

Name_____ Date_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

E-Mail Address_____ Gender: Male___ Female___

Date of Birth_____ Social Security No._____

May I leave you a message? Home Phone___ Cell Phone___ E-Mail___ Text___

Medical History

Name of Primary Care Physician_____

Physician Address_____ Telephone_____

Many managed care organizations require that we have interaction with the client's physician to coordinate care. Do we have your permission to discuss your care with the above listed physician?
Yes_____ No_____

Please sign here for either answer_____

Current medications:

1) _____ Dosage/Frequency _____Start Date _____

2) _____ Dosage/Frequency _____Start Date _____

3) _____Dosage/Frequency _____Start Date _____

4) _____Dosage/Frequency _____Start Date _____

Prescribed by_____

Have you ever been hospitalized for medical or psychiatric reasons? Yes ____ No ____

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History Continued:

Do you drink alcohol? Yes_____ No_____

Type of alcohol How Much How Often

_____ _____ _____

Do you currently use recreational drugs? Yes_____ No_____

Have you used recreational drugs in the past? Yes_____ No_____

If yes, when did you stop?_____

Type of Drug How Much How Often

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke cigarettes or use other tobacco products? Yes_____ No_____

If yes, type and amount_____

Do you gamble? Yes_____ No_____

Please describe any important medical history, chronic ailments, or other health problems you have:

_____

_____

_____

Please describe any other health problems, psychiatric conditions, or important medical history of your immediate family or close relatives:

_____

_____

_____

_____

Social History

Who may I contact in case of emergency?

Name:_____ Phone_____ Relationship_____

Did you experience any developmental, academic, or behavioral problems as a child?

Yes_____ No_____ If yes, please explain:_____

_____

_____

What was the last year of school you completed? _____ If you did not complete high school please explain: _____

_____

How would you describe your current support network, i.e., friends, relatives, etc.: _____

_____

Please check all information which applies to your biological parents:

Mother	____ living	Father	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____ # times		____ remarried ____ # times

Do you consider someone else (step-parent, grandparent, etc.) to be your “real” parent? If so, please explain:_____

_____

Describe your relationship with your mother while growing up: _____

_____

Currently: _____

_____

Social History Continued:

Describe your relationship with your father growing up: _____

_____

Currently: _____

_____

Describe any family problems which occurred while growing up related to alcohol/drug abuse or problem gambling: _____

_____

_____

Physical / sexual / or emotional abuse: _____

_____

_____

Please list the names and ages of your siblings.

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital History

Marital Status: ___single/never married ___Married ___Separated ___Divorced ___Widowed ___Living with someone

If currently married, how long? _____ If living with someone, how long?_____

Do you have previous marriages? If so, please describe:_____

_____

_____

Marital History Continued:

Please list your children:

Name	Age	Relationship (biological / step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Status

Please check any of the following that describe how you have been feeling lately:

___sad ___anxious ___depressed ___frightened ___guilty ___angry ___ashamed ___aggressive

___resentful ___worthless ___tearful ___irritable ___confused ___extreme ups and downs

___jealous ___hopeless ___helpless

Describe any other feelings you have: _____

_____

Have you had any change in sleeping habits? ___Yes ___No If yes, describe:_____

_____

Have you had a change in eating habits? ___Yes ___No If yes, describe:_____

_____

Have you ever considered suicide in connection with your current problem? ___Yes ___No

If yes, is it just an idea, or have you made a plan on how to kill yourself? ___Yes ___ No

If yes, please describe:_____

_____

Have you ever considered suicide in the past? ___Yes ___No If yes, please explain:_____

_____

Mental Status Continued:

Have you attempted suicide recently or in the past? ___Yes ___No If yes, please briefly explain with dates:_____

_____

Have you had any homicidal thoughts recently or in the past? ___Yes ___No If yes, please explain the circumstances:_____

_____

_____

Level of Functioning

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):_____

_____

_____

_____

Thoughts

Please check any of the following that apply to me:

____ I sometimes hear voices even though no one nearby is talking to me.

____ I sometimes feel forces outside of me control me.

____ I sometimes feel other people control my thoughts.

____ I sometimes have the same thought over and over an cannot control it.

____ I sometimes feel someone is out to hurt me or do something against me.

____ I sometimes cannot control my behavior. Please explain:_____

_____

_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

_____

_____

_____

Please list your goals in therapy:

_____

_____

_____

_____

_____

_____

Thank You!

Please sign and date:

_____ _____

Signature Date

JAMES FAUST & ASSOCIATES ● PLLC

Please complete this page if you are using your insurance to pay for counseling.

Primary Insurance	Secondary Insurance
Name of Ins. Co.:	Name of Ins. Co.:
Insurance Phone #	Insurance Phone #
Insured's Name (on card):	Insured's Name (on card):
Insured's ID No.:	Insured's ID No.:
Insured's DOB:	Insured's DOB:
Group or Policy No:	Group or Policy No:
Plan or Program Name:	Plan or Program Name:
Insurance Billing Address:	Insurance Billing Address:
Effective Date:	Effective Date:
Deductible:	Deductible:
Insurance Coverage:	Insurance Coverage:
Co-Pay or Co-Ins.:	Co-Pay or Co-Ins.:
Allowed # of Visits:	Allowed # of Visits:
Date verified / Name of Person:	Date verified / Name of Person:
Referral Required?	Referral Required?
Phone # for referral:	Phone # for referral:

By my signature below I accept assignment of insurance payments for services rendered.

Client Signature _____Date_____