SOLUTION FOCUSED FAMILY CENTER

Interview Office:
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ADULT CLIENT THERAPY INFORMATION/INTAKE FORM

Your Name: _____
Last First Middle Maiden/Other names

Present
Address:_____
Street Apt. # City State Zip Code

Home Phone Number: _____ Cellular Phone Number: _____

Work Phone Number: _____ Email Address: _____

Age: _____ Date of Birth: _____ Drivers License: _____
Number/State

Spouse Name: _____ Okay to Leave a Message With? Yes or No

Employed By: _____ Occupation: _____

Why are you seeking counseling?

_____

_____

_____

_____

Approximately, how long have you had the current problems? _____

In what ways have you attempted to cope with these problems?

_____

_____

_____

_____

Are you currently in counseling elsewhere or have you ever been in counseling in the past for any reason? □ Yes □ No

If yes, please provide the name and phone number of provider:

List or describe any current impediments or problems in your daily psychological, social, or occupational functioning.

_____

_____

_____

_____

List the things that bring you joy and happiness currently:

_____

_____

_____

What do you worry about or fear the most?

_____

_____

_____

What do you hope to gain from counseling?

_____

_____

_____

_____

_____

DAILY FUNCTIONING

Please check any of the following that describe how you believe you feel:

____ *sad*	____ *anxious*	____ *depressed*	____ *frightened*
____ *guilty*	____ *angry*	____ *ashamed*	____ *aggressive*
____ *resentful*	____ *worthless*	____ *tearful*	____ *irritable*
____ *confused*	____*extreme ups/downs*	____ *jealous*	____ *hopeless*
____ *helpless*	____*annoyed*		

Describe any other feelings you have had that concern you: _____

_____

_____

Please check any of the following that apply to you:

- I sometimes hear voices even though no one nearby is talking to me.
- I sometimes feel that other people control my thoughts.
- I sometimes feel that forces outside of me control me.
- I sometimes have the same thought over and over and cannot control it.
- I sometimes feel that someone is out to hurt me or do something against me.
- I am sometimes unable to control my behavior.

Have you had any change in your sleeping habits? (Circle One) YES NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Have you ever considered suicide in connection to your current problem? (Circle One) YES NO

If so, please give a brief description with dates_____

_____

_____

Have you ever considered suicide in the past? (Circle One) YES NO

If so, please give a brief description with dates_____

_____

_____

Have you attempted suicide recently or in the past? (Circle One) YES NO

If so, please give a brief description with dates_____

_____

_____

Have you had any thoughts or hurting other people? (Circle One) YES NO

If yes, please explain: _____

_____

_____

Have you ever considered homicide in the past? (Circle One) YES NO

If yes, please explain: _____

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Street Address: _____ City/ST: _____ Zip: _____

Office Phone Number: _____ Office Fax Number: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Are you currently under the care of a psychiatrist or have been in the past? □ Yes □ No

If Yes, Psychiatrist Name:_____

Street Address: _____ City/ST: _____ Zip: _____

Office Phone Number: _____ Office Fax Number: _____

Date of last psychiatric evaluation: _____ Date of next appointment: _____

Current medications being taken:

Medication #1: _____ Dosage/Frequency: _____

Purpose of medication: _____

Medication #2: _____ Dosage/Frequency: _____

Purpose of medication: _____

Medication #3: _____ Dosage/Frequency: _____

Purpose of medication: _____

Medication #4: _____ Dosage/Frequency: _____

Purpose of medication: _____

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

Hospital	Month/Year	Reason
1.		
2.		

RECREATIONAL DRUG USE		
Do you currently use recreational drugs? □ Yes □ No	If no, have you used previously? □ Yes □ No	If yes, when did you stop?
TYPE OF DRUG	HOW MUCH	HOW OFTEN
1.		
2.		
3.		

ALCOHOL AND TOBACCO USE		
Do you drink alcohol? □ Yes □ No	If no, did you previously drink? □ Yes □ No	If yes, when did you stop?
TYPE OF ALCOHOL	HOW MUCH	HOW OFTEN
1.		
2.		
Do you smoke cigarettes? □ Yes □ No	Do you vape? □ Yes □ No	Do you use other forms of tobacco? □ Yes □ No

Previous Chemical Dependency Treatment □ Yes □ No

Treatment Center/Hospital	Month/Year	Reason
1.		
2.		

Have you ever attended AA or NA □ Yes □ No If yes, when: _____

_____

Extended Family History with diagnosed mental illnesses such as depression, anxiety, bipolar disorder, schizophrenia or other emotional problems? □ Yes □ No If yes, who:

_____

_____

_____

Extended Family History with Alcohol/Drug Problems □ Yes □ No If yes, who:

_____

_____

_____

Describe any important medical history, chronic ailments, or other health problem you experience:

_____

_____

_____

_____

SCHOOL & FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers?

_____

_____

_____

_____

What was the last year of school you completed? Did you graduate high school or college? If not, please explain.

_____

_____

_____

How would you describe your current support system? (relatives, friends, etc.)

_____

_____

_____

_____

Do you consider someone else like a step-parent, grandparent, aunt or uncle to be your real parent? If so, whom?

_____

_____

_____

_____

What was your relationship like with your mother growing up?

_____

_____

_____

_____

Describe your current relationship with your mother?

_____

_____

_____

_____

What was your relationship like with your father growing up?

_____

_____

_____

_____

Describe your current relationship with your father?

_____

_____

_____

_____

List your brothers and sisters:

Name	Age	Relationship (Biological, step, half

Describe any family problems which occurred while growing up.

_____

_____

_____

_____

Did you experience any childhood physical, sexual, or emotional abuse? If yes, please explain.

_____

_____

_____

_____

Was Child Protective Services ever involved in your family? If yes, please explain.

_____

_____

_____

_____

Current Marital status:

□ Single/never married □ Married □ Separated □ Divorced □ Widowed □ Living with someone

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

If separated/divorced, how long: _____ If divorced, how long: _____

If widowed, how long: _____

Describe any concerns in your marriage or relationship with your partner:

_____

_____

_____

How many past significant relationships, marriages, and/or divorces have you had?

Name	Date of Marriage	Date of Divorce

Please list your children:

Name Age Relationship (biological, adopted, step) Parenting time schedule

_____

_____

_____

_____

_____

EMPLOYMENT

Current Place of Employment: _____

Job Title: _____ Work Schedule: _____

How would you describe your current job situation? Please include any stressors you experience at work, such as difficulty leaving work-related issues at home, feelings of stress while on the job, or challenges in your relationships with coworkers or supervisors.

_____

_____

LEGAL HISTORY

Please indicate any instances of legal difficulties, such as indictments, arrests, DWI'S, etc that you have experienced:

_____

_____

_____

Is your reason for coming to see me related to an accident or injury? ❑ Yes ❑ No

If yes, please explain:

_____

_____

_____

Are you required by a court, the police, or a probation/parole officer to have this appointment?

❑ Yes ❑ No

If yes, please explain:

_____

_____

_____

Are your currently, or do you anticipate being involved in a custody dispute?

❑ Yes ❑ No

If yes, please explain:

_____

_____

CONTACT AUTHORIZATION

By providing the information listed above, I authorize Mindy Harrison, LCSW-S, to contact me via the information filled out and provided by me. I reserve the right to revoke this consent by providing Mindy Harrison, LCSW-S written notice.

_____ _____

Client/Guardian Signature Date

SERVICE YOU ARE SEEKING

- ☐ Individual Counseling
- ☐ Couples Counseling
- ☐ Co-Parenting
- ☐ Family Counseling

LEGAL INVOLVEMENT

If you are currently involved in a child custody dispute, please complete the following.

Your Attorney's Name: _____

Street Address: _____

Office Phone Number: _____ Office Fax Number: _____

Is there an Ad Litem or Amicus Attorney assigned?

- ☐ Yes
- ☐ No

If Yes, Ad Litem or Amicus Name: _____

Street Address: _____ City/ST: _____ Zip: _____

Office Phone Number: _____ Office Fax Number: _____

IN CASE OF EMERGENCY

Whom may we contact in the event of an emergency? (Please list a local family or friend not living in the same address)

Emergency Contact #1: _____

Street Address: _____

Home Phone Number:_____ Mobile Phone Number: _____

Emergency Contact #2: _____

Street Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

PLEASE READ THE INFORMATION BELOW THOUROUGHLY

I understand that I am responsible for payment at the beginning of each scheduled appointment time. I also agree to be fully responsible for full payment of services. I understand that Mindy Harrison, LCSW-S is in network with multiple insurance companies such as Blue Cross Blue Shield of Texas, Cigna, Carelon Behavioral Health, Blue Cross Blue Shield of Massachusetts, Quest Behavioral Health, and Aetna. I understand that while Mindy Harrison may be in the process of getting credentialed with other insurance companies, she currently does not bill other insurance companies and it is my responsibility to research and file for out of network insurance benefits. I understand that Mindy Harrison, LCSW-Scan provide a detailed receipt upon my request should I chose to submit for out of network insurance benefits. I hereby consent to treatment by Mindy Harrison, LCSW-S, at Solution Focused Family Center. I understand that my chances of achieving my therapy goals will be best met by actively engaging in the therapeutic process and adhering to the suggestions provided. I acknowledge that I have the right to continue or refuse treatment at any time. Additionally, I understand that I am responsible for any outstanding balance.

_____

Signature of Client Date

_____ _____

Client/Guardian Signature Date