LSC
LIVING SUCCESS CENTER
A Pathway to Mental Health & Wellness

Adult Intake Form

General Information

Name: _____ _____ _____ Date:_____
First Middle Last

Address: _____

Phone: _____
Home Cell Work

What is the best number to reach you at: Home / Cell / Work Email Address: _____

May we leave a text: Yes / No Gender: Female ___ Male ___ Other _____

Age: _____ Date of Birth: _____ Ethnicity_____
MM/DD/YYYY Please list as many as you identify with

Social Security No: _____ Employed: Yes / No

Occupation: _____ How Long? _____

Annual Household Income: _____ # in Household: _____

Currently in School? Yes / No If so: Full Time / Part Time Highest Grade Level Completed: _____

Insurance:_____

Marital and Family Information

Relationship Status: Single / In a Relationship / Engaged / Married / Separated / Divorced / Widowed

# of Previous Marriages for You:_____ # of Previous Marriages for Spouse/Significant Other:_____

# of Years Married:_____ # of Years in Current Relationship:_____

# of Years Divorced: _____ Length of Separation: _____ # of Pregnancies: _____ # of Children: _____

Please list children by age: (include step, adopted, foster children)						
Name	Age	Sex	Education/Grade	Living with whom?	Relationship to You	Special concerns

Please list any other person(s) living in your home:				
Name	Age	Sex	Relationship	Special concerns

I was child number_____ in a family of_____ children.

I was adopted: Yes / No
Circle One

Family History - Indicate if any of the following is true for yourself or a family member						
	Self	Mother	Father	Sibling	Grandparent	Other significant family member - Please Specify:
Depression						
Suicide						
Suicide Attempt						
Alcohol Problem						
Drug Problem						
Mental/Emotional problem						
Abuse						
Other Major Trauma (i.e. rape, combat, etc.) - Please Specify:						

Medical Information

Name, Address & Phone # of Physician:_____

_____

Date of Last Exam:_____ General Health Assessment: _____

List all medications you are now taking (including prescription & non-prescription such as vitamins, etc.):

Name of Medication:	Dosage & How many times a day:	Prescribed by:

Please circle any and all of the following medical you have or have had in the past:

Heart Trouble	Frequent/Severe Headaches	Head Injury/Knocked Unconscious
Diabetes	High blood Pressure	Epilepsy/Seizures/Convulsions
Stroke	Shortness of Breath	Fainting/Dizziness
Kidney Trouble	Bedwetting/Soiling	Stomach Problems
Back Problems	Unusual Bleeding	Asthma/Hay Fever
Arthritis	Sleep Difficulty	Neurological Disease

Any other Serious Illness, Injury, or Surgery:

Type of illness/injury/surgery	Name, Address, &Phone# of Treating Physician	Date of Illness/Injury/Surgery

Prior Psychotherapy - Have you consulted a therapist of any type in the past (Circle one)? YES NO

Name of Counselor/Therapist	Address & Phone #	Date(s) of Service

Have you ever been hospitalized for psychiatric reasons in the past? (Circle one) YES NO

Name of Hospital	Address & Phone #	Date(s) of Hospitalization

Please provide names of people we can contact in case of an emergency

Name of Person	Phone#	Relationship to You

Problem Areas/Areas of Concern

		During the past **TWO (2)WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Clinician Use Only** (Highest Domain Score)
I.	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feel down, depressed, or hopeless?	0	1	2	3	4	
II.	3.	Feeling more irritated, grouchy, angry than usual?	0	1	2	3	4	
III.	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6.	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you nervous?	0	1	2	3	4	
V.	9.	Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12.	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15.	Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks of any kind of alcohol in the same day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g. painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Client Initial _____

Please write a brief statement about the problem(s) or areas of concern that brought you in to counseling:

_____

_____

_____

_____

_____

What do you hope to gain from coming to counseling?

_____

_____

_____

_____

Have things improved in any way since you made your initial appointment? (Circle one) YES NO

If so, how? Please write a brief statement:

_____

_____

_____

_____

Appointment Cancellations Policy:

If an appointment is cancelled or missed without 24 hours prior notice, a regular charge will be made and carried on in your balance. Please note that Monday appointments must be cancelled by noon on Friday.

Whom may we thank for referring you to us? _____

This form was completed by: _____ on _____
Name Date

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A Nonprofit Organization Serving Orange County