Linda Mesing Cook, M.S., LMHC

Adult Intake Form

Today's Date: _____

Client Contact Information:

Your Name: _____

Date of Birth: _____ Age: _____

Birth Sex: _____ Self-Reported Gender: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

May we send mail here? Yes_____ No_____

Home Phone: _____ OK to leave message? Yes_____ No_____

Work Phone: _____ OK to leave message? Yes_____ No_____

Cell Phone: _____ OK to leave message? Yes_____ No_____

Email Address: _____ OK to send email here? Yes_____ No_____

Person to call in case of emergency: _____

Their Phone Number: _____

Current Relationship Status: Single_____ Dating: _____ Committed Relationship_____

Married_____ Divorced_____ Separated_____ Live Together_____ Widowed ____

Sexual Orientation: Heterosexual_____ Gay_____ Lesbian_____ Bisexual_____

Transsexual_____ Other_____

Primary Cultural Background with which you identify: African American/Black_____

Asian_____ Caucasian_____ Biracial_____ Hispanic/Latino_____ Other_____

Referral: Referred by: _____

We are always grateful for referrals. May I thank the professional who referred you here? Yes_____ No_____ (Their contact information: _____)

Employment Information: Employer: _____Length of time: _____

Occupation: _____ Number hours worked/week: _____

Education: Highest Grade/Degree completed: _____Currently in School? Yes_____ No _____

Type of Degree: _____

Relationship Information: Past and Present marriages/significant intimate relationships (first names, years together, nature of relationships (ie-distant, friendly, abusive, hostile, loving)

_____
_____
_____
_____

Children, step-children, grandchildren (first names, ages, brief description of your relationship with that child)

_____
_____
_____
_____
_____

Please identify any family members with mental health, substance abuse or violence issues

_____
_____
_____

Chemical Use: Do you currently use any recreational drugs, tobacco, vape, or drink alcohol?

Yes_____ No_____ Any past substance abuse: _____

_____

Medical: Primary Physician Name: _____ Phone: _____

Physician Address: _____

Are you currently receiving medical treatment: Yes_____ No_____ If yes, please specify:

_____
_____

List any illnesses, surgeries hospitalizations, or traumas related to medical treatment you have had

_____
_____
_____

May I contact your doctor to consult with him/her about your treatment? Yes_____ No_____

Current Medications/dosages:

_____

_____

Religious/Spiritual Issues: Are religious/spiritual issues important to you? Yes_____ No_____

Would you like faith to be a part of your counseling process? Yes_____ No_____

Do you have a personal support system? Yes_____ No_____ (If yes, who?) _____

_____

Legal History: Is your participation in therapy today related to any legal matter? (ie- accident, injury, criminal activity, probation condition, court order, or divorce) Yes_____ No_____

If yes, please explain: _____

_____

Suicide Assessment: Have you ever attempted suicide? Yes_____ No_____ (how long ago did this occur and how many times?) _____

_____

Do you have any current thoughts of ending your life? Yes_____ No_____

Do you have a plan? (please explain) _____

_____

Social/Personal/Leisure: What activities or social involvement help you to feel joy or pleasure in life? _____

_____

Please describe your primary concerns at this time:

_____

_____

_____

_____

Insurance Information: Name of Healthcare Insurance Company _____

_____

Name of Insured Policy Holder: _____

Member Identification Number: _____

Please understand that utilizing health insurance benefits requires this provider to submit personal health information to your insurance company, specifically a procedural code indicating the type of treatment and length of time of the appointment. Additional information

supplied to the insurance company is a diagnostic code for the purpose of reimbursement for services. Information obtained during the clinical process will not be released without your written consent unless court-ordered. Confidentiality may also be waived in situations where a client is in danger to self or others, or there are indications of child or elder abuse/neglect.

Terms of Service: *I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without a 24-hour notice of intention to cancel, I will be charged the full administrative fee for services. Your therapist is available after regular business hours and on weekends by phone. However, an immediate response to your call cannot be guaranteed. Phone consultation after hours in excess of 10 minutes will be billed in accordance with your regular hourly fee. Please understand that in case of emergency, you may need to contact 911 or a local mental health facility or hospital.*

I understand that my participation is purely voluntary and that I may withdraw whenever I wish. All records are the property of Linda Mesing Cook, M..S., LMHC.

I have read and understand all of the information on this form. I give consent for treatment of myself or the client indicated below. I understand that I may discuss with my therapist all aspects of my treatment and any issues on this form.

Client printed name: _____

Client Signature: _____

Date Signed: _____