Diagnostic code_____ CoPay _____

GENERAL INTAKE INFORMATION-ADULT

Client Name:_____ Today's Date:_____

Single____ Married____Divorced____Separated____Widowed____

Referred by:_____

Date of Birth:_____ Age:_____ Gender: M F

Employer:_____Occupation:_____

Name & age of those Living in Household:

_____

Home Address:_____Zip_____

Home Phone: _____Cell Phone: _____

Work Phone:_____ Email:_____

Where would you like us to leave reminder messages?_____

Emergency Contact:_____Phone:_____

Date of Last Physical:_____ Primary Care Physician:_____
PCP Phone_____PCP Fax_____
Current Diagnosis, Medications, Allergies or Medical Concerns:_____
_____

Past Counseling/Testing History:
Date Length of Service Agency/Therapist Providing Service
_____
_____

Briefly Describe why you are seeking counseling or assessment:
_____

Client Signature:_____ Date:_____

Signature indicates consent for Beverly Newman to contact PCP or emergency contact in the rare case an emergency should occur.

Newman Clinical Associates/Sandlot Counseling Center
738 Hwy. 6 South, Suite 300 Houston, TX 77079
Tel (713) 826-1381 Fax (281) 870-9009 www.newmanclinical.com

ADULT INFORMATION/HISTORY

Client Name: _____Clinician Name: _____
Intake/1st Appointment Date: ____/____/____ DOB_____ Age_____

Presenting Complaint (according to Client):

_____
_____
_____
_____
_____
_____
_____

What will your life look like when you no longer need counseling?

_____
_____
_____
_____
_____

Name 3 positive things (strengths) about yourself:

_____
_____

Significant Medical History: _____ YES _____ NO ☐ Allergies ☐ Surgeries ☐ Illnesses
Describe:

_____
_____
_____
_____
_____
_____

Medications at Intake:
Name Dosage Purpose
Prescribing Physician's Name/Telephone No.

_____ _____ _____
_____

_____ _____ _____
_____

_____ _____ _____
_____

Check if any applies to you: (Circle each specific condition)
_____**Cardiovascular:** Heart problems (high blood pressure, chest pain, irregular heartbeat)
_____**Constitutional:** Chronic fever, unexpected weight gain/loss, fatigue
_____**Endocrine:** Cholesterol, Diabetes, Thyroid
_____**Gastrointestinal:** heartburn, stomach pain, diarrhea, vomiting
_____**Genitourinary:** pain or discomfort, blood in urine
_____**Ear/nose/throat problems:** hearing loss, sinus problems, sore throat
_____**Hematologic/Lymphatic:** bruising/bleeding easily, anemia, sickle cell
_____**Immunologic:** HIV positive, Bacterial/Viral Infection
_____**Integumentary:** skin rashes, excessive dryness
_____**Musculoskeletal:** muscle aches, joint pain, swollen joints
_____**Neurological:** numbness, weakness, headaches, paralysis
_____**Psychiatric:** depression, anxiety, _____
_____**Respiratory:** shortness of breath, wheezing, coughing, asthma

Past Mental Health/Chemical Dependence Treatment History? ____ YES ____ NO ____N/A
☐ Inpatient ☐ Day Treatment/PHP ☐ Residential
☐ Outpatient ☐ Structured Outpatient

Dates: **Length:** **Reason:** **Deemed helpful by client?**

_____ _____ _____ **☐ Yes ☐ No**

PERSONAL/SOCIAL: Living arrangements and situation at Intake (check all that apply):
☐ Lives alone ☐ Lives with roommate ☐ Lives with spouse
☐ Lives with parents ☐ Lives with siblings ☐ Lives with children (give ages/gender below)
☐ Other (Specify):
_____

Comments:
_____
_____

Nuclear Family: ☐ spouse ☐ Biological &/or step children
(ages/gender/status):
_____
_____
_____
_____
☐ parents ☐ siblings (ages/gender/status):
_____
_____
_____
_____

Available support network: ☐ Family ☐ Friends ☐ Other
Comments: _____

Degree of Isolation: ☐ none ☐ mild ☐ moderate ☐ severe

SIGNIFICANT FAMILY/DEVELOPMENTAL HISTORY:

Family Psychiatric History? _____ Yes _____ No

☐ Schizophrenia ☐ Depression ☐ Bipolar Illness ☐ Posttraumatic Stress ☐ Anxiety

Additional detail of above:

_____
_____
_____

Family History of Alcohol/Substance Abuse? _____ Yes _____ No

If yes, which family members and which substance(s)?

_____
_____
_____

Childhood Physical or Sexual Abuse? _____ Yes _____ No

If yes, provide details of abuse, including age of onset, duration and type:

_____
_____
_____

Other Significant Family or Childhood History? _____ Yes _____ No

If yes, please provide details:

_____
_____
_____
_____

Work/School Situation at Intake:

Type of work/school (indicate level):

_____

Duration of current job:

_____

Level of satisfaction at work/school: ☐ Low ☐ Medium ☐ High
Level of functioning at work/school: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
(According to: ☐ client ☐ management ☐ other (specify):

_____

Legal Issues at Intake: _____ No _____ Yes (describe):

_____
_____
_____

Sleep Disturbance at Intake: _____ Yes _____ No ☐ mild ☐ moderate ☐severe

_____ Insomnia: ☐ initial ☐ middle ☐ terminal

_____ Hypersomnia (describe):

_____

Onset/Duration:

_____

Appetite Disturbance at Intake: _____ Yes _____ No ☐ mild ☐ moderate ☐severe

_____ Decreased appetite Wt. Loss: _____lbs. In what period of time? _____
Intentional? __Y __N

_____ Increased appetite Wt. Gain: _____lbs. In what period of time? _____

Guilt: ☐ none ☐ mild ☐ moderate ☐severe

Energy level: ☐ within normal limits ☐ impaired (☐ mild ☐ moderate ☐severe)

Concentration: ☐ within normal limits ☐ impaired (☐ mild ☐ moderate ☐severe)

Psychomotor retardation: ☐ none ☐ mild ☐ moderate ☐severe

Loss of interest in usual activities: ☐ none ☐ mild ☐ moderate ☐severe
What do you do for fun?_____

SUICIDAL/HOMICIDAL ____IDEATION ____PLAN ____GESTURES OR ____SELF-INJURIOUS BEHAVIORS AT INTAKE? _____Yes _____No If yes, describe:

_____
_____

Past history of suicidal/homicidal ___ ideation ___ plan ___ gestures ___ self-injurious behaviors? _____Yes _____No If yes, date/describe:

_____
_____

History of Aggressive behavior? _____Yes _____No If yes, describe:

_____
_____

_____ALCOHOL ____SUBSTANCE ABUSE IDENTIFIED AT INTAKE? ____YES ____NO

If other than alcohol, indicate substance(s):
_____
Frequency of use: ☐ daily ☐ weekly ☐ monthly ☐ other (specify):_____
Amount(s) used: _____
Onset/duration: _____
Longest period of sobriety: _____ When?_____
For other substances, indicate physical and psychological symptoms:

_____

For alcohol: ☐ seizures ☐ blackouts ☐ "shakes" ☐ DWI ☐ Public Intoxication
Comments:_____

_____

IS CLIENT WILLING TO ADDRESS THESE ISSUES? _____YES _____NO _____N/A

Beverly Newman, MA, LPC-S, LSSP, RPT-S Newman Clinical Associates/Sandlot Counseling Center

www.newmanclinical.com 738 Hwy. 6 So Suite 300, Houston, TX 77079 Tel (713) 826-1381 Fax (281) 870-9009

About Your Concerns

Please mark all of the items that currently apply, and feel free to add any others under, "Any other concerns." You may add a note or details in the space next to the concerns checked.

- ☐ Abuse-emotional
- ☐ Abuse-neglect
- ☐ Abuse-physical
- ☐ Abuse-sexual
- ☐ Aggression
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention problems
- ☐ Career problems
- ☐ Childhood issues
- ☐ Children-care
- ☐ Children-custody
- ☐ Children-management
- ☐ Choices I have made
- ☐ Codependence
- ☐ Compulsions
- ☐ Compulsive spending
- ☐ Concentration problems
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision making
- ☐ Delusions
- ☐ Dependence
- ☐ Depression
- ☐ Distractibility
- ☐ Divorce
- ☐ Drug abuse-OTC
- ☐ Drug abuse-street drugs
- ☐ Drug abuse-alcohol
- ☐ Drug abuse-prescription drugs
- ☐ Eating-poor appetite
- ☐ Eating-making self vomit
- ☐ Eating- overeating
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Goals not being met
- ☐ Grieving
- ☐ Guilt
- ☐ Headache, pains
- ☐ Health
- ☐ Hostility
- ☐ Impulsive Spending
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment problems
- ☐ Laziness
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Low income
- ☐ Low mood
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Menopause
- ☐ Menstrual problems
- ☐ Mixed feelings
- ☐ Mood swings
- ☐ Motivation
- ☐ Mourning
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitivity to criticism
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobias
- ☐ Physical Problems
- ☐ PMS
- ☐ Poor self care
- ☐ Procrastination
- ☐ Relationship problems
- ☐ Relaxation
- ☐ Re-marriage
- ☐ Risk taking
- ☐ Sadness
- ☐ School Problems
- ☐ Self-abuse-burning
- ☐ Self-abuse-cutting
- ☐ Self-abuse-other
- ☐ Self abuse-scratching
- ☐ Self-centeredness
- ☐ Self- control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual conflicts
- ☐ Sexual desire differences
- ☐ Sexual dysfunctions
- ☐ Sexual-other issues
- ☐ Shyness
- ☐ Sleep-insomnia
- ☐ Sleep-nightmares
- ☐ Sleep-too little
- ☐ Sleep- too much
- ☐ Step-parenting
- ☐ Stress
- ☐ Stress management
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Tension/Stress
- ☐ Thought disorganization
- ☐ Threats of violence
- ☐ Tiredness
- ☐ Tobacco use
- ☐ Violence
- ☐ Work problems
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Employment problems
- ☐ Employment-terminations
- ☐ Employment-lack of
- ☐ Employment-overdoing

Other: _____

_____

_____

_____

Return via email: Proclaims@ProclaimsMB.com

FAX: 1-866-431-8697

Client Insurance Information Verification Request Form

Provider Name: Beverly Newman, MA, LPC-S, LSSP, NCC, RPT-S
Newman Clinical Associates/Sandlot Counseling Center 2014©
Office Location: 738 Hwy 6 South, Ste. 300, Houston, TX 77077
For appointment: 713-826-1381

Client's Name_____

Clients Date of Birth _____

Home Address_____

City_____ Zip _____

Insured's Name _____

Insured's Date of Birth _____Social Security # _____

Insured's Email Address _____

Insured's phone/cell _____

Insurance Company Name _____

Phone number to check benefits for Mental Health _____

ID # _____Group # _____

Employee Assistance Program (EAP) Benefits Provider_____

EAP Phone Number to check benefits for Mental Health_____