Adult Intake Form

Client's name: ______________________________________ Date: _______________________

Gender: ____ F ____ M Date of birth: _____________Age: _______ SSN: _________________

Form completed by (if someone other than client):_______________________________________

Address: ______________________________________ City: _______________ State: ________

Zip: __________

Phone (Home): ______________________ (Cell:) _______________________

Is it okay to leave message? Yes: ______ No: ______

(Work): _________________________ Ext: ________

email: ____

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1) ________________________ Relationship _________________ Phone _____________

Address _________________________ City _______________ State ____Zip_______________

Physician ____ Phone ________________

Address _________________________ City _______________ State ____Zip_______________

Psychiatrist ____ Phone ______________

Address _________________________ City _______________ State ____Zip_______________

Other Physicians ____ Phone ____________________

Current Medications ____

Allergies ____

If you need any more space for any of the questions, please use the back of this sheet.

Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping

____ Depression ____ Eating disorder ____ Fear/phobias

____ Mental confusion ____ Sexual concerns ____ Sleeping problems

____ Addictive behaviors ____ Alcohol/drugs _____grief and loss

____ Other concerns
(specify):____
____
____
____

FAMILY INFORMATION

Living with you

Significant others (e.g., brother, sisters, grandparents, step-relatives, half relatives. Please specify relationship.)

Relationship Name Age

______________ ______________________________ ________ ___good____ fair ____ poor

______________ ______________________________ ________ ___good____ fair ____ poor

______________ ______________________________ ________ ___good____ fair ____ poor

______________ ______________________________ ________ ___good____ fair ____ poor

Marital Status:

____ Single____ Unmarried, living together____ Married____ Separated____ Divorced____ Widowed

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married ____ Mother remarried: Number of times: ________

____ Parents have never been separated ____ Father remarried: Number of times: ________

____ Parents never divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? ____ Yes ____ No

If Yes, please describe:

____
____
____
____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ inadequate nutrition ____ other (please specify):

____
____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn

Eden COUNSELING SERVICES

Financial Agreement Form

I agree to the following financial payment and procedures.

1. To pay $150 for the initial assessment and $100 per 50 minute session thereafter.
2. To pay a prorated fee for consultations over the phone that involves therapeutic issues other than obtaining and canceling appointments.
3. To pay an hourly rate of $100 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, treatment summaries, and so forth.
4. Payment is expected at the beginning or end of each session, unless prior arrangements have been made.
5. *Appointments not cancelled 24 hours in advance* will be charged to my account and must be paid at the next session.
6. A $20 service charge will be added to all returned checks and must be paid at the next session.
7. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy only and does not guarantee that all fees will be covered by insurance
8. Explanation of any alternate payment plan: ____

☐ ***I would like Eden Counseling Services to bill my insurance.***

Initials

Insurance Information

Name of Insurance Company: ____

Insurance Company Address: ____

(City)___________________________(State)__________(Zip Code)______________

Phone Number: ____________________

Subscriber Name: ____________________________Date of Birth: ________________

Place of Employment: ____

Policy ID or Social Security Number: ____

Group Number: _______________

I understand the above payment procedures and I agree to this plan of payment.

Client Signature _________________________________ Date ______________

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