Crossroads
COUNSELING CENTER

ADULT INTAKE

Name: _____
DOB: _____
Chart #: _____
MID/Ins #: _____
MID/Ins #: _____

CLIENT INFORMATION

DATE _____

First Name	Middle Name	Last Name		
Address	City	State	Zip	County
Home Phone	Cell Phone	Work Phone		
Date of Birth / Age	Sex: ☐ Male ☐ Female ☐ Other	Preferred Language:		
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐More than one race ☐Native Hawaiian ☐Pacific Islander ☐White ☐Decline to report	Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to report			

INSURANCE INFORMATION (Copy of Insurance Card/s Required)

Primary Insurance Name:	**Secondary Insurance Name:**
Subscriber Name / Date of Birth	Subscriber Name / Date of Birth
Subscriber's Address	Subscriber's Address
Subscriber's Telephone #	Subscriber's Telephone #
Client's Relationship to Insured ☐Spouse ☐Partner ☐Child ☐Self	Client's Relationship to Insured ☐Spouse ☐Partner ☐Child ☐Self
Subscriber ID # / Group ID #	Subscriber ID # / Group ID #

Emergency or imminent risk contact:
Name: _____ Telephone# _____ Relationship:_____

How did you hear about us?
___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

Crossroads offers appointment reminders. Check below all the ways you wish to receive a reminder.

☐ To Be Called Telephone Number _____
☐ Text Message Text Number _____
☐ Emailed Email Address _____

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Individuals participating in assessment: _____

Employment/Education

Employment Status ___ Employed ___ At-Home Parent ___ Student
___ Unemployed ___ Disabled ___ Military

Employer _____ ___ Full-Time ___ Part-Time
Job Title / Occupation _____

Highest level of education completed _____
If student, list school _____
Course of study _____

Household Information

Current status of significant relationship:

___ Single ___ Separated ___ Living together ___ Dating ___ Other
___ Married ___ Divorced ___ Life partner ___ Widowed

List all members of your household:

Name	Relationship to You	Age

Who were you raised by? _____
List significant family relationships who do not live with you (parents, siblings, close grandparents, caregivers, etc.)

Name	Relationship	Still living?
		___ Yes ___ No
		___ Yes ___ No

Social Information

Spiritual preference: _____
List any support systems: _____
Hobbies and community activities: _____

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Medical History Have you experienced any of the following? (If yes, explain.)

___ Childhood trauma _____
___ Adult trauma _____
___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
___ Significant family medical history _____
___ Significant family mental health history _____
___ Significant family substance history _____
___ Prior mental health diagnosis _____
___ Prior developmental diagnosis _____

Primary care physician _____

Current medications Name Dosage

_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy Name _____ Telephone # _____
Address _____

Substance Use History

Alcohol _____
Illegal Drugs _____
Prescription Drugs _____
Smoking ☐ Non-Smoker ☐ Current Smoker ☐ Ex-Smoker ☐ Smokeless Tobacco
Other _____

Legal Involvement

List any charges/arrests/convictions: _____
_____

Mental Health Treatment History

List all mental health treatment, substance abuse treatment or hospitalizations

Facility/Therapist	Purpose	Current	Past

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Response to Treatment: _____

Other agency services/relationships in the last six months:

___ Child Protective Services ___ Justice System ___ Outpatient Mental Health
___ Other DSS Services ___ Disability/Social Security ___ Outpatient Substance Abuse
___ Occupational Therapy ___ Speech therapy ___ Other: _____

Current Treatment Focus

What brings you to our office today? _____
_____
_____
_____

What services are you seeking?

___ Individual Therapy ___ Psychological/Educational Testing
___ Family Therapy ___ Psychiatric Services or Medication Management
___ Couples Therapy ___Other (explain): _____

I/we would like to address the following: (check all that apply)

___ My mood or emotional state (depression, anxiety, anger, etc.)
___ My behavior / choices ___ Sleep, eating, or physical concerns
___ My cognitive / mental functioning ___ Relationships with family or peers
___ School / academic performance ___ Divorce
___ Parenting ___ Grief / Loss
___ Abuse, neglect, or trauma history ___ Workplace issues
___ Adjustment to new cultural ___ Other: _____

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Adult Assessment: Check all the following that currently apply.
Indicate past concerns with the letter "P".

____ Anxiety	____ Hurts others	____ Hyperactive
____ Depressed mood	____ Lying	____ Attention problems
____ Panic attacks	____ Stealing	____ Worries all the time
____ Racing thoughts or speech	____ Destroying property	____ Impulsive
____ Obsessions/Compulsions	____ Defiance	____ Low self-esteem
____ Excessive fears or phobias	____ Blames others for mistakes	____ Suicidal thoughts
____ Dissociative states	____ Angry/resentful	____ Suicide attempts
____ Touchy/irritable	____ Lack of conscience	____ Self-harming
____ Nightmares	____ Bizarre behavior	____ Sexually acting out
____ Sleep problems	____ Clingy	____ Pornography
____ Incontinence or bedwetting	____ Separation anxiety	____ Difficulty with change
____ Rage or "meltdowns"	____ Seems to overreact	____ Needs predictability/routine
____ Conflicting parenting styles	____ Feels overwhelmed	____ Unexplainable mood shifts
____ Parental/marital problems	____ Argumentative	____ Running away
____ Adoption/foster care history	____ Life has been unstable	____ Deliberately annoys people
____ Lots of physical complaints	____ Life changes pending	____ Takes excessive risks
____ Eating issues	____ Cultural Adjustments	____ Experienced discrimination
____ Addictions	____ Loss due to death	____ Loss due to other

Use the space below to tell us anything else you would like for us to know in order to best help you:

_____
_____
_____
_____
_____

I certify that the information provided in this document is correct to the best of my knowledge.

_____ _____
Client Signature **Date**