

Client Admission Form

Client Name: _____ Sex: _____ Date of Birth: _____
Insurance: _____ Date of Evaluation: _____

Reason for seeking counseling including background information:

Check the current symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Isolation/Withdrawal | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Homicidal Ideation | <input type="checkbox"/> Aggression/Violence | <input type="checkbox"/> Anxiety/Panic |
| <input type="checkbox"/> Appetite Problems | <input type="checkbox"/> Poor Impulse Control | <input type="checkbox"/> Phobia/Fear |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Destructive Behavior | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Anger/Irritability | <input type="checkbox"/> Victim of Abuse | <input type="checkbox"/> Bizarre Behavior |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Perpetrator of Abuse | <input type="checkbox"/> Problems Thinking/Concentrating |
| <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Addictive Behavior | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Intense Family Distancing | <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Stress/Feeling Overwhelmed |
| <input type="checkbox"/> Communication/Trust Problems | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Legal/Financial Problems |
| <input type="checkbox"/> Chronic Medical Problems | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Religious/Spiritual Issues |
| <input type="checkbox"/> Binging/Purging | <input type="checkbox"/> Sexual/Intimacy Issues | <input type="checkbox"/> Tearful/Crying Spells |

If Client is under 18, check current symptoms below in addition to those above:

- | | | |
|--|---|---|
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Inattention | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Oppositional Behavior |
| <input type="checkbox"/> Lying/Manipulative Behavior | <input type="checkbox"/> Aggression | <input type="checkbox"/> Destruction of Property |
| <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Risk Taking Behavior | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Running Away | <input type="checkbox"/> School Problems | <input type="checkbox"/> Unusual birth/pregnancy events |
| <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Blended Family Issues |

Previous Treatment: **Yes No** If yes, please indicate dates, whether inpatient/outpatient, problem for which you were treated, and name of treating professional:

Please list any allergies/drug sensitivities: _____

Indicate Current Medications, Dosage: _____

Name and Phone Number of Prescribing Professional: _____

If not on medication, is a referral for a medication evaluation needed? **Yes No**

Name and Phone # of Primary Care Physician: _____

Permission to contact Primary Care Physician regarding treatment: **Yes No**

Please list past & present tobacco, alcohol, and drug use:

List Strengths/Accomplishments:

Client Signature _____

Date _____

Client Signature _____

Date _____