HERITAGE
FAMILY COUNSELING SERVICES

400 N. Woodlawn, Ste 106
Wichita, KS 67208
(316) 461-7923
fax 260-7045

Adult Intake Form

NAME: _____ _____ _____
First Name | Middle Initial | Last Name

DOB: _____ **AGE:** _____ **SS NUMBER:** _____ **GENDER:** ☐ Male ☐ Female

ADDRESS: _____ **APT.#:** _____

CITY: _____ **STATE**: _____ **ZIP**: _____

PHONE NUMBER: _____ _____ _____
Home | Cell | Work

E-MAIL ADDRESS: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

PLEASE LIST ALL PERSONS (INCLUDING YOURSELF) CURRENTLY LIVING IN YOUR HOUSEHOLD.

	NAME	RELATIONSHIP	DOB	AGE	OCCUPATION/YEARS OF EDUCATION
1.					
2.					
3.					
4.					
5.					

DESCRIBE YOUR FAMILY, CULTURE AND RELIGIOUS CONNECTIONS: _____

_____

_____

WHO REFERRED YOU TO US: _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT: _____

IS TREATMENT COURT ORDERED? ☐ Yes ☐ No

SPIRITUALITY:

Would you describe your spiritual beliefs as producing: ☐ Comfort ☐ Stress ☐ N/A
Are you an active participant in a religious community? ☐ Yes ☐ No ☐ N/A

Would you like the counseling process to include:

Scripture discussion: ☐ Yes ☐ No
Prayer: ☐ Yes ☐ No

SELF/FAMILY MENTAL HEALTH HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

_____ INDIVIDUAL THERAPY	_____ MARITAL THERAPY	_____ FAMILY THERAPY	_____ SEX THERAPY
_____ DOMESTIC VIOLENCE	_____ ANGER MANAGEMENT	_____ GROUP THERAPY	_____ GRIEF
_____ LOSS	_____ ANXIETY	_____ DEPRESSION	_____ ADHD
_____ SEXUAL ABUSE	_____ PHYSICAL ABUSE	_____ BIPOLAR DISORDER	_____ EATING DISORDER
_____ PSYCHIATRIC HOSPITALIZATIONS	_____ SCHIZOPHRENIA	_____ ANTISOCIAL BEHAVIOR (HISTORY OF VIOLATING THE LAW)	_____ DRUG USE
_____ ALCOHOL USE	_____ OTHER SUBSTANCES_____	_____ OTHER ADDICTIONS_____	

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

_____ ASTHMA	_____ HIGH BLOOD PRESSURE	_____ KIDNEY DISEASE	_____ DENTAL PROBLEMS
_____ CANCER	_____ THYROID PROBLEMS	_____ LIVER DISEASE	_____ TUBERCULOSIS
_____ DIABETES	_____ SEASONAL ALLERGIES	_____ HEART DISEASE	_____ HEAD INJURY
_____ HEARING ISSUES	_____ SEIZURES	_____ ALLERGIES	_____ OTHER

CURRENTLY PRESCRIBED MEDICATIONS AND PRESCRIBING PHYSICIAN:

_____

_____

CURRENT GENERAL FUNCTIONING: (Please mark each that apply.)

_____ CHEERFUL/HAPPY MOOD MOST OF THE TIME	_____ SAD OR TEARFUL MOST OF THE TIME	_____ FEELINGS OF HOPELESSNESS/ EMPTINESS
_____ WITHDRAWN BEHAVIORS/ ISOLATION	_____ DIFFICULTY CONCENTRATING	_____ UNDER ACTIVE/SLUGGISH BEHAVIOR
_____ DECREASE IN INTERESTS/ACTIVITIES	_____ FEELINGS OF GUILT	_____ DOWN MOST DAYS
_____ DECREASED APPETITE	_____ INCREASED APPETITE	_____ WEIGHT GAIN
_____ WEIGHT LOSS	_____ NO ENERGY	_____ OVERLY FATIGUED DURING THE DAY
_____ SUICIDAL THOUGHTS	_____ SUICIDE ATTEMPTS	_____ INTENTIONAL SELF-HARM (I.E. CUTTING)
_____ POOR SELF-CARE/POOR HYGIENE	_____ POOR MEMORY	_____ EXTREME UPS AND DOWNS IN MOOD
_____ WORRY	_____ PANIC	_____ AVOIDANT
_____ STRESS	_____ IRRITABILITY	_____ ANGER
_____ TAKES MORE THAN AN HOUR TO FALL ASLEEP	_____ NIGHT WAKING FOR LONGER THAN 30 MINUTES	_____ HARD TO WAKE UP IN THE MORNING
_____ UNABLE TO SLEEP IN OWN BED THROUGH THE NIGHT	_____ FEARFUL OF PLACES, SITUATIONS OR PEOPLE	_____ FAST/RAPID SPEECH FEEL RESTED AFTER 3-4 HOURS SLEEP
_____ FEARLESS/ENGAGING IN RECKLESS ACTIVITIES	_____ EXAGGERATED VIEW OF ABILITIES	_____ LYING
_____ THREAT TO HURT SOMEONE WITH INTENT /PLAN	_____ PHYSICAL AGGRESSION	_____ CONFLICT WITH AUTHORITY FIGURES
_____ STEALING	_____ PHYSICAL CRUELTY TO ANIMALS	_____ PROPERTY DAMAGE
_____ VERBAL THREATS TO HARM OTHERS	_____ THOUGHTS OF HARM TO OTHERS	_____ INABILITY TO REMAIN SEATED

_____ EXPLOSIVE OUTBURSTS	_____ DISTINCT PERIODS OF NONSTOP ACTIVITY	_____ POOR SOCIAL SKILLS
_____ LEGAL PROBLEMS	_____ EXTREME CONFLICT WITH OTHERS	_____ GRADIOSITY-UNREALISTIC SENSE OF SUPERIORITY
_____ PROBLEMS WITH SCHOOL PERFORMANCE	_____ PROBLEMS WITH WORK PERFORMANCE	_____ INABILITY TO COMPLETE TASKS
_____ INABILITY TO SUSTAIN ATTENTION	_____ EASILY DISTRACTED	_____ OVERACTIVE/HYPERACTIVE
_____ IMPULSIVITY	_____ COMPULSIONS	_____ DENIAL
_____ NIGHTMARES	_____ SLEEPWALKING	_____ WETTING ACCIDENTS
_____ SEXUAL CONCERNS	_____ EXCESSIVE MASTURBATION	_____ PAIN DURING INTERCOURSE
_____ PROBLEMS WITH RELATIONSHIPS	_____ JEALOUSY	_____ BLENDED FAMILY
_____ DIVORCE	_____ MARITAL AFFAIR	_____ FAMILY CONFLICT
_____ MARITAL PROBLEMS	_____ TRUST	_____ ENABLING
_____ SHAME	_____ CRISIS	_____ CONCERNS WITH ELDER CARE
_____ CONCERNS WITH CHILD CARE	_____ DISABILITY	_____ EMPLOYMENT
_____ INTENTIONAL PURGING	_____ INTENTIONAL VOMITING	_____ HOARDING FOOD
_____ BINGE EATING	_____ ANOREXIA	_____ BULIMIA
_____ OBESITY	_____ BODY IMAGE	_____ SELF-ESTEEM

AUTHORIZATION AND CONSENT

By signing below you are authorizing Heritage Family Counseling Services to provide you with mental health services. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Signature X _____ Date_____

BILLING INFORMATION: *If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.*

PAYMENT OPTION: ☐ INSURANCE ☐ SELF-PAY ☐ OTHER _____

PRIMARY INSURANCE POLICY INFORMATION:

Primary Insurance Company: _____

Insurance Member I.D. Number: _____ Insurance Group Number (or none): _____

Effective Date: _____

PRIMARY INSURANCE INSURED PERSON INFORMATION:

Client's relationship to insured (i.e. self, spouse, child, other): _____

Insured Name: _____

Insured's Street Address: _____

Insured's City: _____ Insured's State: _____ Insured's Zip Code: _____

Insured's Phone Number: _____

Insured's Date of Birth: _____ Insured's Gender: ☐ Male ☐ Female

Insured's Employer: _____

By signing this agreement below you agree to and acknowledge each of the following conditions.

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Heritage Family Counseling Services will notify you in writing.
4. You assume responsibility for any and all fee's rendered associated with services including document preparation fees provided at Heritage Family Counseling Services.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30.00 charge.
7. You are responsible for notifying Heritage Family Counseling Services of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow Heritage Family Counseling Services to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Heritage Family Counseling Services shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name_____ Date _____

Signature X _____