HERITAGE
FAMILY COUNSELING SERVICES

6525 E. Mainsgate
Wichita, KS 67226
(316) 461-7923
fax 260-7045

Adult Intake Form

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

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

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

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

PHONE NUMBER: _____ _____ _____
Home | Cell | Work

E-MAIL ADDRESS: _____

IN CASE OF AN EMERGENCY PLEASE IDENTIFY ONE PERSON YOU AUTHORIZE YOUR CLINICIAN TO CONTACT:

NAME: _____ **PHONE NUMBER:** _____

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 or prayer?

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

SUBSTANCE USE: (Please mark each that apply with "1" current and "2" past)

_____TOBACCO _____ALCOHOL _____NON-PRESCRIPTION DRUGS _____OTHER

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_____

SELF/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	_____ GRANDIOSITY-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 _____