

Rob Reinhardt, M.Ed., LPC, NCC
Adult & Adolescent Intake Form

CLIENT INFORMATION

Last Name:	First Name:
Date of Birth: Social Security #:	Age: Sex:
Mailing Address:	City/State/Zip:
Home Number:	Cell Phone:
Employer:	Occupation:
Employer Phone Number:	Email:
Who referred you to Rob?	Other family members seen by Rob:

BILLING INFORMATION

Person Responsible for payment:	Home Phone Number:
Mailing Address (if different):	City/State/Zip:
Primary Insurance Company:	Policy Number:
Date of Birth:	Client's Relationship to Party Responsible for Billing:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Contact Number 1: Contact Number 2:
Relationship to the Client:	Additional Info:

The information above is accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor providing services when applicable. I understand that I am ultimately financially responsible for any balance. I authorize Rob Reinhardt, M.Ed, LPC, NCC or my insurance company to release any information required to process my claims.

 CLIENT'S/GUARDIAN SIGNATURE

 TODAY'S DATE

HISTORY

1. Have you had prior counseling? If so, how long ago and with whom?

2. Are you currently taking any medication? If so, please list the name of medication dosage.

3. Describe your current use of alcohol and/or drugs.

4. Do you have a family history of mental illness? If so, please explain.

5. Have you ever been treated for substance abuse? If so, when, where, and for what substance(s).

6. Have you ever attempted suicide or had a plan to harm yourself? When?

7. Do you currently have any thoughts and feelings of wanting to physically harm yourself? If so, please explain.

8. Have you ever been diagnosed with an eating disorder? If so, explain.

9. Have you ever been sexually abused or worry that you might have been?

10. Briefly describe any medical conditions that may be affecting your wellbeing.

11. Have your sleeping and/or eating habits changed within the last 3 months? If so, please explain. _____

12. Describe your current social functioning. _____

13. Describe your current academic/vocational functioning.

14. What are your goals for counseling? _____

SYMPTOM CHECKLIST

Please check the following that you feel applies to you.

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Naïve	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	Unattractive	<input type="checkbox"/>	Nervous
<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	Fearful	<input type="checkbox"/>	Bored
<input type="checkbox"/>	Wanting to hurt self	<input type="checkbox"/>	Timid	<input type="checkbox"/>	Restless
<input type="checkbox"/>	Drug use	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	Worthwhile	<input type="checkbox"/>	Empty feelings
<input type="checkbox"/>	Incompetent	<input type="checkbox"/>	Regrets for past	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Controlling	<input type="checkbox"/>	Misunderstood	<input type="checkbox"/>	Tense
<input type="checkbox"/>	Shy	<input type="checkbox"/>	Sympathetic	<input type="checkbox"/>	Poor academic performance
<input type="checkbox"/>	Don't take vacations	<input type="checkbox"/>	Intelligent	<input type="checkbox"/>	Worthless
<input type="checkbox"/>	Confused	<input type="checkbox"/>	Fainting spell	<input type="checkbox"/>	Stupid
<input type="checkbox"/>	Considerate	<input type="checkbox"/>	No appetite	<input type="checkbox"/>	Evil
<input type="checkbox"/>	Disabled	<input type="checkbox"/>	Regular alcohol use	<input type="checkbox"/>	Over ambitious
<input type="checkbox"/>	Not confident	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Good person
<input type="checkbox"/>	Cannot make decisions	<input type="checkbox"/>	Inadequate	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Few friends	<input type="checkbox"/>	Disturbing thoughts	<input type="checkbox"/>	Attractive
<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	Guilty	<input type="checkbox"/>	Lonely
<input type="checkbox"/>	Feelings of panic	<input type="checkbox"/>	Hateful	<input type="checkbox"/>	Not loved
<input type="checkbox"/>	Trembling	<input type="checkbox"/>	Inferior	<input type="checkbox"/>	Confident
<input type="checkbox"/>	Unable to relax	<input type="checkbox"/>	Bad home environment	<input type="checkbox"/>	Cannot keep a job

Please add any additional information that you would like for your counselor to know. _____
