Recovery Pathways, LLC
863 N. Pine Rd, Suite A, Essexville, MI 48732
Phone: 989-928-3566 **Fax: 989-391-9596**

ADULT INTAKE FORM

***Please complete all questions on this form (please print)**

Today's date_____/_____/_____

Name of person filling out this form:_____
(Relationship to client)

CLIENT INFORMATION

Your Name:_____Date of Birth:_____/_____/_____

Address:_____City:_____Zip:_____

Home Phone: (_____)_____Cell: (_____)_____

Social Security Number:_____Age:_____ Gender: [ ] Male [ ]Female

Marital Status: [ ]Never Married [ ]Married [ ]Cohabitating [ ]Separated [ ]Divorced

Number of years married/cohabitating:_____

Spouse's/Partner's name and phone numbers:_____

Please list the names and ages of your children including step-children:

_____

_____

Employment: [ ]Employed [ ]Full Time Student
[ ]Unemployed [ ]Part Time Student
[ ]Other (specify)_____

Name of current employer:_____

Name of school (when applicable):_____

Highest level of education completed:_____

IN CASE OF EMERGENCY

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you – perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and contact information for your emergency contact person.

Name:_____Relationship to you:_____

Phone Number(s):_____

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CLIENT HISTORY

1. Have you ever received counseling, psychological, alcohol or drug treatment before?
[ ]Yes [ ]No If yes, please indicate:
From Whom? For What? When? With what results?

_____

_____

2. Have you ever been prescribed medications for psychiatric or emotional problems?
[ ]Yes [ ]No If yes, please indicate:
From Whom? For What? When? With what results?

_____

_____

3. Please list any psychiatric or substance abuse hospitalization(s): (please include dates of treatment)_____

_____

4. Please list name of your primary care physician:_____

_____
Phone Number Address City Zip

May Recovery Pathways contact your primary care physician to coordinate your care?
[ ]Yes [ ]No

5. Do you have a family history of mental illness or substance abuse? If so, please explain:_____

_____

6. Please list any current medications (include name of doctor prescribing medication and any over the counter medications or herbal remedies):_____

_____

7. Please list any allergies and what symptoms occurred:_____

_____

8. Please list any health related conditions or concerns:_____

_____

9. Do you have any current legal charges, court involvement or under court order to receive services?
[ ]Yes [ ]No If yes, please explain:_____

_____

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10. What are the reasons why you are currently seeking counseling?_____

_____

11. What are your goals for counseling?_____

_____

SYMPTOMS LIST – PLEASE CHECK ALL THAT APPLY:

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear or phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Abusing others		Chronic pain
	Blaming or criticizing self		Feeling a need to be on the go		Dizziness
	Feeling tired		Antisocial or illegal behavior		Problems at home
	Anxiety		Abused by others		Concerned about family
	Irritability		Disorganized thoughts		Sick often
	Isolating self		Impulsivity		Relationship problems
	Distractibility		Drug allergies		Poor judgment
	Working memory problems				Social anxiety

Please add any other information that would be helpful for the provider to know:_____

_____

_____

_____

REFERRAL INFORMATION

Referred to Recovery Pathways by:_____
May I have permission to thank this person for the referral? [ ]Yes [ ]No