

Hillcrest Family Services- Outpatient Services Adult Client Information

Thank you for taking time to fill out the following confidential information. The information provided will assist us in providing you quality services.

Intake Date: _____

CLIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Birthdate: ___/___/___ Social Security #: _____ Gender: male female

Address: _____
Street Apt# City State Zip Code

Relationship Status: single married divorced separated widowed significant other

Military Service: yes no Number of yrs: _____ Education level: _____

Currently employed? yes no Employer: _____

Primary Contact Phone _____ home cell work other Okay to leave message? yes no

Secondary Contact Phone _____ home cell work other Okay to leave message? yes no

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

LEGAL INFORMATION

Legal Status: Independent adult Adult with guardian (if adult with guardian please complete following)

Guardian's Name: _____

Address: _____
Street Apt# City State Zip Code

Primary Contact Phone _____ home cell work other Okay to leave message? yes no

Secondary Contact Phone _____ home cell work other Okay to leave message? yes no

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____ City: _____

Psychiatrist: _____ Phone: _____ City: _____

Are you seeing other professionals? yes no Please list: _____

Current medication(s)

Medication Name	Dosage	Prescribed by	Prescribed for

Do you have any current medical conditions or allergies? yes no

Please list: _____

INSURANCE/BILLING INFORMATION

All of the following information is required. Please identify who is responsible for payments/co-pays. Split billings to multiple individuals are not possible.

Individual responsible for payments: _____
Name Relationship to Adult

Billing Address: _____
Street City State Zip Code

Are you covered as part of Employee Assistance Program? yes no Employer: _____

Street City State Zip Code

List **Primary Insurance**: _____ Policy# _____ Group# _____

Insured Adults Name: _____ Birthdate: ____/____/____ SS# _____

Relationship to Client: _____ Insured's Address: _____

Insured's Employer: _____
Name Street City State Zip Code

Insurance Claim Address: _____
Street City State Zip Code

List **Secondary Insurance**: _____ Policy# _____ Group# _____

Insured Adults Name: _____ Birthdate: ____/____/____ SS# _____

Relationship to Client: _____ Insured's Address: _____

Insured's Employer: _____
Name Street City State Zip Code

Insurance Claim Address: _____
Street City State Zip Code

SUPPORTING INFORMATION

Who currently lives in your home with you?

Full Name	Relationship	Age	Education level

Please list any important events from your childhood/adult life your therapist should know about. (deaths, violence, divorce, etc)

Please check all that apply to you :

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> agitation | <input type="checkbox"/> chest tightness | <input type="checkbox"/> aggression | <input type="checkbox"/> distractible |
| <input type="checkbox"/> change in appetite | <input type="checkbox"/> dizziness | <input type="checkbox"/> cruelty | <input type="checkbox"/> easily frustrated |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> dyspnea | <input type="checkbox"/> destructive | <input type="checkbox"/> fails to complete tasks |
| <input type="checkbox"/> depressed/sad | <input type="checkbox"/> headaches | <input type="checkbox"/> fights | <input type="checkbox"/> fidgety |
| <input type="checkbox"/> difficulty coping | <input type="checkbox"/> irritable | <input type="checkbox"/> fire setting | <input type="checkbox"/> forgetful |
| <input type="checkbox"/> discouraged | <input type="checkbox"/> palpitations | <input type="checkbox"/> run away/truant | <input type="checkbox"/> hyperactive |
| <input type="checkbox"/> helplessness | <input type="checkbox"/> poor sleep | <input type="checkbox"/> theft | <input type="checkbox"/> impatient |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> restless | | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> irritable | <input type="checkbox"/> tense nervous | <input type="checkbox"/> compulsions | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> tiredness/fatigue | <input type="checkbox"/> obsessions | <input type="checkbox"/> poorly organized |
| <input type="checkbox"/> loss of energy | <input type="checkbox"/> trembling | | <input type="checkbox"/> procrastinates |
| <input type="checkbox"/> loss of interest | <input type="checkbox"/> worry | <input type="checkbox"/> angry | <input type="checkbox"/> reactive |
| <input type="checkbox"/> loss of motivation | | <input type="checkbox"/> argues | <input type="checkbox"/> short attention span |
| <input type="checkbox"/> sense of guilt | <input type="checkbox"/> agitation | <input type="checkbox"/> blames others | <input type="checkbox"/> working below capacity |
| <input type="checkbox"/> sleep difficulty | <input type="checkbox"/> dizzy | <input type="checkbox"/> defiant | |
| <input type="checkbox"/> thinking slowed | <input type="checkbox"/> excessiveness | | <input type="checkbox"/> other |
| <input type="checkbox"/> weight gain/loss | <input type="checkbox"/> grandiose | <input type="checkbox"/> agoraphobia | |
| <input type="checkbox"/> worthlessness | <input type="checkbox"/> minimal sleep | <input type="checkbox"/> chest pain | |
| <input type="checkbox"/> suicidal ideation | <input type="checkbox"/> racing thoughts | <input type="checkbox"/> derealization | |
| | | <input type="checkbox"/> fear of dying | |
| <input type="checkbox"/> avoidant | <input type="checkbox"/> binges | <input type="checkbox"/> palpation | |
| <input type="checkbox"/> flashbacks | <input type="checkbox"/> body image distortion | <input type="checkbox"/> shakes/trembles | |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> fear of weight gain | <input type="checkbox"/> short of breath | |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> loss of menstrual cycle | <input type="checkbox"/> sweats | |
| <input type="checkbox"/> startles | <input type="checkbox"/> purges | <input type="checkbox"/> nausea | |
| <input type="checkbox"/> trauma | | | |
| <input type="checkbox"/> vigilante | | | |

TREATMENT HISTORY

Have you seen other mental health professionals? yes no Please list w/dates: _____

Have you ever been treated in a hospital or other placement setting? yes no

Please list w/dates: _____

Completed by: _____
(please print)