

Client Admission Form

Client Name:

Sex:

Date of Birth:

Client ID#:

Payment: cash / credit / check

Date of Evaluation:

Reason for seeking counseling including background information:

Check the current symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Aggression/Violence | <input type="checkbox"/> Phobia/Fear |
| <input type="checkbox"/> Homicidal Ideation | <input type="checkbox"/> Poor Impulse Control | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Appetite Problems | <input type="checkbox"/> Destructive Behavior | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Victim of Abuse | <input type="checkbox"/> Bizarre Behaviors |
| <input type="checkbox"/> Anger/Irritability | <input type="checkbox"/> Perpetrator of Abuse | <input type="checkbox"/> Problems Thinking |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Addictive Behavior | <input type="checkbox"/> Problems Concentrating |
| <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Alcohol/substance Abuse | <input type="checkbox"/> Stress/Feeling Overwhelmed |
| <input type="checkbox"/> Intense Family Distancing | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Legal/Financial Problems |
| <input type="checkbox"/> Communication/Trust Problems | <input type="checkbox"/> Parenting Issues | <input type="checkbox"/> Religious/Spiritual Issues |
| <input type="checkbox"/> Chronic Medical Problems | <input type="checkbox"/> Sexual/Intimacy Issues | <input type="checkbox"/> Tearful/Crying spells |
| <input type="checkbox"/> Binging/Purging | <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Isolation/Withdrawal | <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Other: _____ |

If Client is under 18, Check current symptoms below in addition to those above:

- | | | |
|---|---|---|
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Destructive of Property |
| <input type="checkbox"/> Inattention | <input type="checkbox"/> Aggression | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Lying/Manipulative Behaviors | <input type="checkbox"/> Risk-taking Behavior | <input type="checkbox"/> Unusual Birth/ Pregnancy |
| <input type="checkbox"/> Fir Setting | <input type="checkbox"/> School Problems | <input type="checkbox"/> Blended Family Issues |
| <input type="checkbox"/> Running Away | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Night Terrors | |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Oppositional Behaviors | |

Previous Treatment: Yes / No If yes, please indicate dates, whether inpatient/outpatient, problem for which you were treated, and name of treating professional

Please List any allergies/drug sensitivities: _____

Indicate Current Medication, Dosage: _____

Name and Phone number of Prescribing Profession: _____

If not on medication, is a referral for a medication evaluation needed? Yes / No

Name and Phone # of Primary Care Physician: _____

Permission to contact Primary Care Physician regarding treatment: Yes / No

List past and present tobacco, alcohol, and drug use:

Client Signature _____

Date: _____

If under 18 years old Signature of parent or guardian: _____