

Huron Valley Consultation Center
Ann Arbor, Michigan

_____ Date

_____ Case #

ADULT INTAKE INFORMATION

_____ Name _____ Home Phone _____ Business Phone

_____ Cell phone/other phone _____ Email

_____ Street Address _____ City _____ State _____ Zip Code

_____ Date of Birth _____ Sex _____ Marital Status: Single Married Divorced
Widowed Living with partner

_____ Age _____ SSN _____ Driver's License #

Referred by: _____

In Case of emergency, contact (Name, relationship and phone number):

PLEASE CIRCLE FORM OF PAYMENT: CASH INSURANCE

_____ Primary Insurance _____ Policyholder's Name _____ Relationship _____ Policyholder DOB

_____ Contract Number _____ Group Number _____ Policyholder's Employer _____ Policyholder SSN

_____ Secondary Insurance _____ Policyholder's Name _____ Relationship _____ Policyholder DOB

_____ Contract Number _____ Group Number _____ Policyholder's Employer _____ Policyholder SSN

It is important to HVCC to be responsive to our patients' needs and your feedback is very useful to us. Please rate the timeliness of scheduling your first appointment:

Excellent	Good	Fair	Poor	Very Poor
5	4	3	2	1

****FOR STAFF USE ONLY****

_____ **DSM-IV _____ Code

_____ Therapist Signature _____ Therapist Code
Print Name: _____

Insurance	Deductible	Copay	Yearly maximum	Lifetime max
Primary				
Secondary				

If applicable:
Authorization #: _____ Number of sessions: _____ Dates covered: _____

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What are your reasons for seeking treatment at this time?

Have you seen a mental health or substance abuse professional (psychiatrist, psychologist, or social worker) in the past? If yes, explain.

Have you ever taken medications for a mental health, emotional problem, or substance abuse problem? If yes, explain.

Have you attended any self-help groups? If so, explain.

Family Information

Spouse's name

Spouse's Date of Birth

Spouse's Occupation

Children's Name(s), age(s), sex. Specify if child lives at home. Previous marriage(s) and children.

List significant extended family members. (Parent, brothers and sisters, etc.)

Explain any family history of physical illness or significant hospitalizations.

Explain any family history of mental or emotional illnesses, psychiatric hospitalization, history of suicide.

Any family history of substance abuse? Who was that? What substance(s) was abused?

Please describe any spiritual/religious/cultural affiliations.

Are social supports adequate at present? (Family, friends, co-workers)

Occupational/Educational History

Current employer and your job title

General satisfaction with your job

List past jobs and any comments:

Are you satisfied with your overall financial status? If not, explain.

Highest grade completed:

Describe your school performance:

Do you have any future plans for education? If yes, describe.

Leisure Activities

List some of your hobbies, activities, and talents.

With whom do you spend most of your free time?

Medical History

Name and address of your primary care physician

Height:_____ Weight:_____

When was your last physical exam?

Do you have any allergies? If yes, explain.

List all prescribed medications you are taking. Include dosage and frequency.

List all over-the-counter (including vitamins, minerals, diet pills, supplements, herbs, and other “natural” remedies) you are taking.

Have you ever had a problem with overuse of prescribed medications? If yes, explain.

Describe any surgeries, serious accidents, or hospital admissions.

Indicate whether you have had any of the following illnesses/symptoms.

	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Anemia					High blood pressure				
Arthritis					Immune problems				
Asthma					Kidney disease				
Cancer					Paralysis				

	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Diabetes					Prostate problems				
Earaches, infections					Seizures, epilepsy				
Emphysema					STDs				
Fainting/dizziness					Sleep problems				
Excessive fatigue					Stroke				
Headaches					Thyroid disease				
Head injury					Ulcers (GI)				
Heart problems					Urinary infections				
Hepatitis					Vision/hearing problems				
Other:					Other:				

Do you have physical pain? Yes _____ No _____

If yes, rate the intensity of the pain: 1(mild) to 5 (severe): _____.

If yes, where is the pain located: _____.

If yes, how does it impact your functioning?

Do you drink coffee, tea, cola, or consume other food, beverages, or medicines with caffeine? If so, please describe how much per day?

Please provide information on your use of non-medical drugs.

Substance	Used within 48 hrs.?	How often used?	Year first used?	When last used?
Cigarettes/tobacco				
Alcohol				
Sleeping pills				
Marijuana				
Inhalants				
Cocaine/crack				
Heroin				
Other:				

Military History

Branch	Rank	Time in service	Active combat

Legal History

Do you have any pending or prior legal problems? If yes, explain.

Other:

Is there anything else you think we ought to know about you or you would like to tell us?

Patient Signature: _____ **Date:** _____

For therapist use only:

If it has been over a year since the patient's last physical, did you suggest that he/she have a physical?

Yes _____ No _____ Did the patient agree to this? Yes _____ No _____

Therapist/MD signature: _____ Date: _____

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ADULT SYMPTOM CHECKLIST

NAME: _____ AGE: _____ DATE: _____

Please circle the symptoms that apply to you now in the past few weeks:

	Never	Rarely	Sometimes	Always		0	1	2	3	4	5		
Depression	0	1	2	3	4	5	On the go, hard to relax	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5	Periodic overspending	0	1	2	3	4	5
Hopelessness	0	1	2	3	4	5	Gambling problem	0	1	2	3	4	5
Worthlessness	0	1	2	3	4	5	Alcohol problem (in the last year)	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5	Drug problem (in the last year)	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5	Blackouts, shakes, tremors	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5	Anxiety/panic attacks	0	1	2	3	4	5
Early morning waking	0	1	2	3	4	5	Heart beating fast	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5	Chest pains/tightness	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5	Lightheadedness	0	1	2	3	4	5
Overeating	0	1	2	3	4	5	Stomach upset	0	1	2	3	4	5
Weight loss or gain	0	1	2	3	4	5	Sexual difficulties	0	1	2	3	4	5
If so, how much in the last 3-6 months:							Relationship problems	0	1	2	3	4	5
Gained: _____ Lost: _____							Work problems	0	1	2	3	4	5
Lack of interest in usual things	0	1	2	3	4	5	Eating disorder	0	1	2	3	4	5
Suicidal thoughts, present	0	1	2	3	4	5	Suspiciousness/paranoia	0	1	2	3	4	5
Suicidal thoughts, past	Yes _____ No _____						Feeling controlled	0	1	2	3	4	5
Suicide attempt, gesture	Yes _____ No _____						Hitting/domestic violence	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5	Hearing voices (that others don't)	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5	Seeing things (that others don't)	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5	Need for cleanliness	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5	Need for organization	0	1	2	3	4	5
Racing thoughts	0	1	2	3	4	5	Counting behavior/thoughts	0	1	2	3	4	5
Hard to concentrate/ stay focused on task	0	1	2	3	4	5	Rituals that you must do/ need to check and recheck	0	1	2	3	4	5
Fatigue/tiredness	0	1	2	3	4	5	Unexplained physical symptoms	0	1	2	3	4	5
Bursts of energy	0	1	2	3	4	5	Trauma, other abuse	0	1	2	3	4	5
Worry	0	1	2	3	4	5							
Fears of ordinary things (for example, crowds, germs, doctors, flying, closed spaces)	0	1	2	3	4	5							
Yelling/screaming	0	1	2	3	4	5							