

**Dr. Andy Brown, LPC  
Adult Intake Form**

**CLIENT INFORMATION**

Last Name:	First Name:
Date of Birth:	Age: <span style="float: right;">Sex:</span>
Mailing Address:	City/State/Zip:
Home Number:	Cell Phone:
Employer:	Occupation:
Employer Phone Number:	Email:
Who referred you to Dr. Andy Brown?	Other family members seen by Dr. Andy Brown:

**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 Dr. Andy Brown, LPC or my insurance company to release any information required to process my claims.

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CLIENT'S/GUARDING SIGNATURE

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TODAY'S DATE

**HISTORY**

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

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

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

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

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

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

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

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

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

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

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

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12. Describe your current social functioning.

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13. Describe your current academic/vocational functioning.

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14. What are your goals for counseling?

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### 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 on the reverse side of this document.