MorningStar Counseling Center

INTAKE INFORMATION

Name: ________________________________ Date: ______________________

Date of birth: ___________________________ Age: _______________________

Social Security No.: ______________________ Telephone No: (W) ___________

(H) ___________

Address: ______________________________ City: _____________ Zip: _____ County: ________

Emergency Contact Name: ______________________________________ Phone No.: (W) ___________

(H) ___________

GENERAL INFORMATION: Check All That Apply to You:

___ Married ___ Disabled
___ Separated ___ Employed
___ Single ___ Unemployed
___ Divorced ___ Student

EDUCATIONAL INFORMATION:

Highest School Grade Completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 Years of college 1 2 3 4
Have you ever experienced learning difficulties or educational problems as a student? ___ Yes ___ No

SPIRITUAL INFORMATION: Is spirituality / religion a part of your life? ___ Yes ___No
If so, how is this relationship helpful? ____
To which church do you claim membership? ____

☐ Active ☐ Moderate ☐ Inactive

EMPLOYMENT HISTORY:

	Type of work	Length of time	Reason for leaving
Current Job:	___________________	___________________	_______________________
Previous Jobs:	___________________	___________________	_______________________
	___________________	___________________	_______________________

HOUSEHOLD INFORMATION: Check all that apply to you – In my home I live with ……

___ Spouse ___ Significant Other ___ Brother / Sister ___ Aunts / Uncles
___ Mother ___ Father ___ Foster Parents ___ Grandparents
___ Step-mother ___ Step-father ___ Child(ren) ___ Step-children
___ Other (explain): ____

If you have children, how many do you have and what are their ages? ______________________________

What number child were you in your family? ________ of how many? __________
What number child was your current spouse? ________ of how many? __________

MEDICAL HISTORY:
Are you currently on prescription medication? ___ Yes ___ No If yes, list meds: ______________________
If so, please list name and phone number of prescribing physician: ___________________________________
Have you ever had any serious medical problems? ___ Yes ___ No
If yes, describe the problem(s): ____
Have you experienced any of the following medical problems?

___ Blackouts
___ Shakes
___ Manic Episodes
___ Hallucinations
___ Head Injury
___ Nightmares
___ Hospitalization
___ Depression
___ Panic Attacks
___ Compulsions or Obsessions
___ Addictive Behavior
___ Other (explain) ________________________________

SOCIAL / EMOTIONAL INFORMATION: I need help dealing with: (Check all items that apply)

___ Parent / Child Conflict
___ Family Conflict
___ Poor Communication
___ Getting into Fights
___ Smoking
___ Feeling Tense / Anxious
___ Being Forgetful
___ Being Sad
___ Feeling Agitated / Nervous
___ Being Afraid
___ Marital Problems
___ Not Liking Myself
___ Being Shy
___ Being Sexually Active
___ Dealing with Legal Authorities
___ Obtaining Food
___ Money Problems
___ Feeling Confused
___ Depression
___ School / Work Performance
___ Abusing Drugs or Inhalants
___ Abusing Alcohol
___ Feeling Lonely
___ Feeling Angry or Violent
___ Sexually Transmitted Disease
___ Loss of Energy
___ Not Sleeping
___ Family Member Abusing Alcohol or Drugs
___ Wanting to Hurt Someone or Something
___Wanting to Hurt Myself

ADDITIONAL INFORMATION: Answer all that apply to you:

___ Yes ___ No Have you or any family member ever been affected by alcohol and/or drug abuse?
___ Yes ___ No Have you ever received mental health services before?
___ Yes ___ No Are you interested in sex education and birth control?
___ Yes ___ No Have you ever been tested for AIDS or other sexually transmitted diseases?
___ Yes ___ No Have you or any family member ever been addicted to prescription drugs?
___ Yes ___ No Have you been abused in any way? If so, how? ______________________________
___ Yes ___ No Are you being abused now? If so, how and by whom? ________________________
____

What happened recently that prompted you to come for counseling? ______________________________
____
____
____
____

What have you tried before to solve this problem and how effective was it? _________________________
____
____
____
____

What parts of your life have been affected by the problem? ____
____
____
____
____

Have you previously sought counseling? ____

Was it helpful? ____

FAMILY HISTORY:

1. Father

   Age: _____ Occupation: ____
   Does / Did your father use alcohol / drugs? ____
   How often? __________________________________How much? ________________________________
   Rate and describe your relationship with your father: (1-10: 1=poor, 10=great) __________________
   ____
   Do you have a stepfather? ___ Yes ___ No If yes, rate and describe your relationship with him.
   ____
   ____

2. Mother

   Age: _____ Occupation: ____
   Does / Did your mother use alcohol / drugs? ____
   How often? _______________________________ How much? __________________________________
   Rate and describe your relationship with your mother: (1-10: 1=poor, 10=great) _________________
   ____
   Do you have a stepmother? ___ Yes ___ No If yes, rate and describe your relationship with her.
   ____
   ____

3. Name / Age / Do they use Alcohol/Drugs? / Rate relationship with them (1-10):

	Name	Age	Do they use Alcohol/Drugs?	Rate relationship with them (1-10)
Brothers	________________	____	____________	_____
	________________	____	____________	_____
	________________	____	____________	_____
Sisters	________________	____	____________	_____
	________________	____	____________	_____
	________________	____	____________	_____

Were there other people who were important in your growing up? Explain: ________________________
____

LEGAL HISTORY:

If you have been in trouble with the authorities, please answer the following question.
Do you have any current legal issues pending? Explain. ____
____
____

BILLING INFORMATION:

How will you be paying for these health care services? ____
Source of payment: ___ Self ___ Insurance ___ Medicaid ___ Friend ___ Church Other: ______________
Are you interested in the sliding scale option? ____
Will you be receiving any financial help from outside sources? _______________________________________

If using insurance, complete name of Insured: _________________________________ Date of Birth: _______

SSN: ___________________ ID#: _______________ Group#: ________________ Copay Amount: $_____

Name of Insurance Co.: ____

Address of Insurance Co.: ____ Phone #: __________________

Type of plan (HMO, PPO, POS, Out of Network): ___________ Employer: ___________________________

What is your plan use? (How many sessions you are authorized for, etc.) _____________________________

(Please present your card so we can make a copy of it for our files.)

I authorize MorningStar Counseling Center to contact my insurance provider and to release any information necessary for the determination of benefits to its authorized agents. I understand that I am responsible for any portion of payment that my insurance company refuses to pay at time of collection.

____
Signature