**A BEAUTIFUL MIND**
*Counseling and Psychological Services*

53846 Generations Drive
South Bend, Indiana 46635
Telephone: (574) 243-9370
Fax: (574) 243-9375

6910 N. Main Street, Suite 4
Granger, Indiana 46530
Telephone: (574) 855-3570
Fax: (574) 855-3284

**LINDA MONROE, Ph.D., HSPP**
**RACHEL MICKELSON, PSY.D., HSPP**
**DEBORAH KRIEGEL, M.A., LMHC**
**LORI LUPRESTO, LMHC, LLC**
**DEBORAH COOK-CLARDY, M.A., LMHC**
**SHERRI KELLER, M.A., LMHC**
**ROSETTA DELOOF-PRIMMER, LCSW**
**SARAH MAUCK, PH.D., HSPP**

**STEPHANIE MCPHERRIN, M.A., LMHC**
**MARI CHAMBERLIN, M.S.**
**CHARLEY BURNS, M.S.**
**PAIGE REYNOLDS, M.A., LMHCA**


Adult Intake Sheet

Date____________

Name______________________________________________________________________
Last First Middle Date of Birth

Age: ________Sex: M F Identified Gender:__________________________________________

Address __________________________________________________________________
Street City State Zip

Home Phone (____) ____________________ Cell (____) ________________ Soc. Sec# ________________

May you be contacted by email?__________If yes, email address________________________________

Would you like reminder notifications? _________If yes please choose one of the following methods:

By text (data charges may apply depending on your plan): Cell (___) ____________________________

Automated phone call: Phone (_____)______________________________________________________

Marital Status: (Circle One) Married Single Separated Divorced Widowed

Spouse's Name__________________ Birthdate _______________ Soc. Sec. #________________

Address (if different from above)__________________________________________________________
Street City State Zip

Emergency Contact_________________________________________________________________

Address____________________________________Telephone #: (_____)_________________________

Child/Children Names Birthdate Age Natural/Adopted/Foster

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Turn over for next page ->

EMPLOYMENT

Client's Employer:______________________________ Address:_________________________________

May you be contacted at work?________ If Yes, Phone #: (___)__________________________________

Job title: ____________________________________________________________________________

Spouse's Employer:_____________________________ Address:_________________________________

FINANCIAL RESPONSIBILITY

Who is financial responsible for the bill and how will it be paid?______________________________

Who is the insured? (person who the policy is under/through) Name:____________________________

Insured Date of Birth and relationship to the client:_____________________________________________

Insured Employer:______________________________Address:_________________________________

Name of Insurance Company:______________________________ Phone:_________________________

Group #_______________________ ID#__________________ Copay $______________ Deductible $______________

HEALTH INFORMATION

Family Physician: ______________________________________________________________________

Name Address Phone

On medication now: ________If yes, type, dosage and reason for taking it:_______________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Medications recently taken:___________________________________________________________

Allergies:____________________________________________________________________________

Significant health problems:__________________________________________________________

Last physical exam:____________________Current health: (Good) (Poor) (Average)

Previous counseling, therapy, or psychiatric treatment?_____________________________________

If yes, doctor, facility, or agency: (Include dates, names and addresses if known)_______________________

___________________________________________________________________________________

___________________________________________________________________________________

By whom were you referred?___________________________________________________________

Is this condition accident related?_______________________________________________________

What do you see as the problem (situations and symptoms)? ___________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Turn over for next page ->

Please circle any of the following problems which pertain to you.

Marriage Problems
Being a Parent
Separation
Divorce
Alcohol Use
Drug Use
Anger
Temper
Sleep Problems
Nightmares
Relaxation
Legal Matters
Too Much Energy
Too Little Energy
Family

Loneliness
Education
Career Choices
Stress
Memory
Inferiority Feelings
Appetite/Eating
Moodiness
Fears
Suicidal Thoughts
Relationships
Finances
Work Problems
Tiredness
Ambition

Concentration
Troublesome Thoughts
Urge to Repeat Actions
Nervousness
Shyness
Depression
Sexual Problems
Self-control
Unhappiness
Health Problems
Headaches
Pain Management
Stomach Problems
Bowel Problems
Decision Making

Turn over for next page ->