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
ELLIOT A. FISCH, LCSW
DEBORAH KRIEGEL, M.A., LMHC
JOAN L. PONTIUS, M.S., LMHC
MARIBEL X. SMITH, M.S.
LORI LUPRESTO, LMHC, LLC
STEPHANIE MCPHERRIN, M.A., LMHC
MARIANNE WEST, LCSW
MARI CHAMBERLIN, M.S.
CHARLEY BURNS, M.S.

Adult Intake Sheet

Date____________

Name____
Last First Middle Date of Birth

Address ____
Street City State Zip

Home Phone (_____)_______________ Cell (_____)_________________Soc. Sec#___________________

May you be contacted by email? ______ If yes, email address____________________________________

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 Natural/Adopted/Foster

____

____

____

EMPLOYMENT

Client's Employer:______________________________ Address:________________________________

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

Job title: ____

Spouse's Employer:_____________________________ Address:________________________________

Turn over for next page ->

FINANCIAL RESPONSIBILITY

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

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 name and address if known)

By whom were you referred?____

Is this condition accident related?____

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

____

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 ->