

Dr. Christopher Barrilleaux, DSW, MATH, MSW, LCSW-BACS

Licensed Clinical Social Worker

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Intake Questionnaire - Adults

By answering this questionnaire completely and honestly you will assist me in gathering the information I need in order to help you. The information disclosed is considered *Confidential & Privileged* and will not be released to any other party without your express written consent.

NAME _____ SOC SEC # _____ insurance/ only

ADDRESS _____ DAY PHONE _____

CITY/STATE _____ NIGHT PHONE _____

ZIP CODE _____ CELL / PAGER _____

BIRTHDATE _____ E-MAIL _____

TODAY'S DATE _____

Referral Information & Other Disclosures

REFERRED BY: _____

Whom do we contact in case of an emergency? _____

Your relationship to this person? _____ Phone _____

Who is responsible for your bill? _____

Your relationship to this person? _____

May we verify this information with the guarantor of your account? _____

Personal & Medical Information

Occupation: _____ Employer: _____

Educational Level: *Circle one of the following:*

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

Degrees earned or worked toward: _____

Do you have any children? _____

<i>Name of Child</i>	<i>Age</i>	<i>Parent's Names</i>

Are you currently in a partnered relationship? Yes No

If yes, what is the first name of your partner? _____

What are your hobbies? _____

Have you had prior treatment or counseling before? Yes No

Treatment Agency **Name of Doctor /Therapist** **Reason for Treatment**

Are you presently on any medication? Yes No

If yes, please list: _____

Have you ever taken any psychiatric medications? Yes No

Who is your primary care physician? _____

When is the last time you had a physical examination? _____

How many times have you been hospitalized? _____ If yes, for what? _____

Are you currently being treated for any illnesses? ____Yes ____No If yes, please list:

Do you have (had you had) any injuries? ____Yes ____No If yes, please list:

Do you currently see a psychiatrist? ____Yes ____No If yes, who?

What is your main reason for being here today?

Clinical Information

Place a check (√) by all which apply. Put two checks (√√) for more serious problems and three checks (√√√) for the ones you consider really severe:

- | | |
|--|---|
| <input type="checkbox"/> depression | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> marital problems |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> work or school performance |
| <input type="checkbox"/> feeling down, blue | <input type="checkbox"/> agitation |
| <input type="checkbox"/> money problems | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> worried about my spouse | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> drug abuse | <input type="checkbox"/> difficulty making friends |
| <input type="checkbox"/> medical problems | <input type="checkbox"/> worried about my child |
| <input type="checkbox"/> thoughts of suicide | <input type="checkbox"/> worried about the future |
| <input type="checkbox"/> haunted by my past | <input type="checkbox"/> stress |
| <input type="checkbox"/> anger | <input type="checkbox"/> demons |
| <input type="checkbox"/> seeing things | <input type="checkbox"/> masturbation |
| <input type="checkbox"/> highly irritated | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> chemical dependency | <input type="checkbox"/> gambling |
| <input type="checkbox"/> overeating | <input type="checkbox"/> anorexia or bulimia |
| <input type="checkbox"/> inability to concentrate | <input type="checkbox"/> short attention span |
| <input type="checkbox"/> cravings | <input type="checkbox"/> I'm told I have a temper |
| <input type="checkbox"/> stuttering / stammering | <input type="checkbox"/> obsessive thoughts |
| <input type="checkbox"/> sluggishness | <input type="checkbox"/> deviant fantasies |
| <input type="checkbox"/> feeling misunderstood | <input type="checkbox"/> problems relaxing |
| <input type="checkbox"/> people are trying to frame me | <input type="checkbox"/> my partner is an addict |
| <input type="checkbox"/> problems at work | <input type="checkbox"/> problems at school |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> sexual addiction |
| <input type="checkbox"/> attention deficits | <input type="checkbox"/> low frustration-tolerance |
| <input type="checkbox"/> problems with intimacy | <input type="checkbox"/> sexual dysfunction |
| <input type="checkbox"/> female problems | <input type="checkbox"/> violence |
| <input type="checkbox"/> homicidal thoughts | <input type="checkbox"/> feeling unloved |
| <input type="checkbox"/> unemployment | <input type="checkbox"/> arguments with the ones I love |
| <input type="checkbox"/> banking overdrafts | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> obesity | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> migraine headaches | <input type="checkbox"/> being overweight |
| <input type="checkbox"/> respiratory problems | <input type="checkbox"/> manic-depression |
| <input type="checkbox"/> compulsive behaviors | <input type="checkbox"/> urges to steal |
| <input type="checkbox"/> germs and cleanliness | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> HIV | <input type="checkbox"/> perfectionism |
| <input type="checkbox"/> afraid of getting old | <input type="checkbox"/> death of a loved one |
| <input type="checkbox"/> afraid I may be gay | <input type="checkbox"/> living with a control freak |
| <input type="checkbox"/> partner's immaturity | <input type="checkbox"/> family problems |
| <input type="checkbox"/> bipolar disorder | <input type="checkbox"/> no one to talk to |
| <input type="checkbox"/> keeping secrets | <input type="checkbox"/> people are out to get me |
| <input type="checkbox"/> parenting | <input type="checkbox"/> a loved one is terminally ill |

Insurance

Insured's Name: _____

Insured's Birthdate: _____ Insured's Employer _____

Insurance: _____ Group # _____

Policy or Subscriber #: _____

Policyholder Birthdate: _____

Verification Phone _____

Address to submit claims: _____

Release of Information

I, _____, the undersigned, authorize the Provider to release confidential information limited to diagnostic impression and dates of services to the insurance carrier. Further records release will require new consent forms.

Patient Signature

Date

Assignment of Benefits

I, _____, the undersigned, authorize benefits from my insurance plan to be paid directly to the Provider. I understand that in the event my insurance carrier pays a benefit check directly to me, the patient, that I am responsible for paying my provider directly.

Patient Signature

Date