Janet G. Nestor MA LCMHC DCEP
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Adult Intake

Personal Information:

Name: First_____ M.I. _____ Last _____ Sex: ☐ M ☐ F

Address:_____/_____/_____/_____
Street City State Zip code

Phone: Home:_____ Work:_____ Cell:_____

Date of Birth: _____ Social Security # _____ - _____ - _____Email:_____

Emergency Contact Information:

Name: First_____ M.I. _____ Last _____

Phone: Home _____ Work _____ Cell _____

Address:_____/_____/_____/_____
Street City State Zip code

Relationship to You:_____

Insurance Information

Marital Status: ☐ Single ☐ Married ☐ Other_____

Employment Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Retired

Is your condition related to: ☐ Employment? ☐ Auto Accident? State _____ ☐ Other Accident

Will your treatment be covered by an EAP Program? ☐ No ☐Yes: EAP/Contact Person:_____

Are you under your employer's health plan? ☐No ☐ Yes: Employer's Name _____

Policy Holder: (if policy holder is the client listed above, check here ☐ and skip to **)

Name: First_____ M.I. _____ Last _____ Sex: ☐ Male ☐ Female

Phone: Home _____ Work _____ Cell _____

Address:_____/_____/_____/_____
Street City State Zip code

Insured date of birth _____SS# of insured: _____-_____-_____

Relationship to client: ☐ Spouse ☐ Parent ☐ Other

***If you are covered under another Health Benefit Plan,
please fill out another cover sheet and write "Secondary Insurer" on the top of the form.***

Individual's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below:

Signed _____ **Date:** _____

Insured or Authorized Person's Signature: I authorize payment of medical benefits to Janet G. Nestor for services:

Signed _____ **Date:** _____

Thank you for your patience and cooperation in completing this form. Your responses will help us make effective use of our first session together.

☐ I received Janet G. Nestor's Disclosure Form and was given the opportunity to ask questions.

Basic Background Information

Birthplace:_____ Marital status: _____ Religious affiliation _____
Education: Highest Grade Completed _____ Degree:_____ Military history:_____
Children (First name, age):
_____
_____
Persons living in your home:
_____
Employment status:_____ What type of work do you do (or if retired, what did you do)?
_____

Counseling History, Needs and Goals

Please tell us, briefly, about your reasons for seeking counseling:

_____
_____
_____
_____
Who referred you here? _____
Is counseling mandated? ☐ Yes ☐ No If yes, by whom _____

Please tell us about past and current counseling/psychiatric experiences:

Provider	Where?	When?	How long?	Useful?
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N

Are you currently having suicidal thoughts: ☐ Yes ☐ No If yes, please describe:_____
_____
_____
Have you ever made a suicide attempt? ☐ Yes ☐ No If yes, when and how:_____
_____
_____
Has anyone related to you made a suicide attempt? ☐ Yes ☐ No If yes, please tell us about it:_____
_____
Are you currently having homicidal thoughts: ☐ Yes ☐ No If yes, describe:_____
_____
_____
Have you, or anyone related to you, ever attempted a homicide? ☐ Yes ☐ No If yes, please tell us about it_____
_____
Do you worry about your safety in your current living situation? ☐ Yes ☐ No If yes, please explain:
_____
_____
Have you ever struck or threatened people or animals or broken things in your home?
☐ Yes ☐ No If yes, please tell us about it:
_____
_____

What are your *strengths*?

☐ bright ☐ insightful ☐ motivated ☐ active ☐ good listener
☐ have self-control ☐ have friends ☐ can calm myself ☐ mostly healthy ☐ stable
☐ can ask for help ☐ keep my boundaries ☐ have moral ethics ☐ have employment
☐ can forgive ☐ can express feelings ☐ have enough money to meet my needs ☐ patient
☐ resourceful ☐ sense of humor ☐ compassionate ☐ can solve problems
☐ satisfied with employment ☐ willing to learn new attitudes and behaviors ☐ can accept love & care from others
☐ other strengths:_____

Please check any *concerns* you are having:

☐ Loss of loved one through death ☐ Separation from loved one ☐ Divorce
☐ Change of jobs ☐ Loss of employment ☐ Lifecycle transition
☐ Marriage ☐ Employment conflicts ☐ Stress
☐ Spouse/significant other conflict ☐ Family conflict ☐ Parenting issues
☐ Custody issues ☐ Pregnancy ☐ Fertility issues
☐ Behavior of adult children ☐ Health problems ☐ Retirement
☐ Health problems in family ☐ Victim of physical abuse ☐ Financial problems
☐ Substance abuse ☐ Gambling ☐ Eating disorder
☐ Excessive computer use ☐ Weight management ☐ Rape
☐ Pornographic interest ☐ Violent/abusive behavior ☐ School problems
☐ Interpersonal problems ☐ Housing problems

Please check any *symptoms* that apply to you:

☐ headaches ☐ dizziness ☐ fainting spells ☐ heart palpitations
☐ stomach trouble ☐ anxiety ☐ fatigue ☐ bowel disturbances
☐ no appetite ☐ anger ☐ insomnia ☐ nightmares
☐ panicky feeling ☐ drink a lot ☐ feel tense ☐ conflict with others
☐ tremors ☐ use drugs ☐ allergies ☐ suicidal ideas
☐ depressed ☐ unable to relax ☐ sexual problems ☐ shy with people
☐ don't like vacations ☐ overambitious ☐ feel driven ☐ can't make friends
and week-ends ☐ inferiority feelings ☐ can't keep a job ☐ memory problems
☐ lonely ☐ financial problems ☐ excessive sweating ☐ can't concentrate
☐ unable to have a good time ☐ can't make decisions ☐ home conditions bad
☐ often use aspirin or painkillers ☐ other:_____

Please check any words that you think apply to you:

☐ worthless ☐ useless ☐ a "nobody" ☐ "life is empty" ☐ inadequate
☐ stupid ☐ repulsive ☐ naïve ☐ incompetent ☐ "can't do anything right"
☐ guilty ☐ evil ☐ hostile ☐ full of hate ☐ jittery
☐ agitated ☐ morally wrong ☐ cowardly ☐ horrible thoughts ☐ unassertive
☐ panicky ☐ aggressive ☐ ugly ☐ deformed ☐ unattractive

Social History

Please list your brothers and sisters and their ages _____
_____

Was your childhood unusual in any way? ☐ Yes ☐ No If yes, how?_____
_____

If you have you been married, how often and how long? _____
_____

Have you experienced any significant traumatic events? _____
_____

Have you experienced any significant losses?_____
_____

Please describe any significant legal history (i.e., arrest, bankruptcy) _____
_____

Is there anything else that you want us to know? _____
_____

Medical History

Family Physician:_____ Date of last physical examination:_____
Other Medical Prescribers seen and why:_____
_____

Please check any illness you *currently* have *or* have had *in the past*:

☐ Diabetes ☐ High Blood Pressure ☐ Lung Disease ☐ Venereal Disease (syphilis/gonorrhea)
☐ Asthma ☐ Low Blood Pressure ☐ Cancer
☐ Arthritis ☐ Heart Disease ☐ Kidney Disease ☐ Head Injuries
☐ Pneumonia ☐ Thyroid Disease ☐ Hepatitis ☐ Jaundice
☐ Anemia ☐ Tuberculosis ☐ Cirrhosis ☐ Muscular Disorder
☐ Ulcer ☐ Colitis ☐ Bone Disorder ☐ Obesity
☐ Seizures ☐ Nerve Disorder ☐ Anorexia ☐ AIDS/HIV
☐ Depression ☐ Anxiety ☐ Other Mental Illness
☐ Alcohol/Drug Problems ☐ Other (please describe) _____

Please tell us about your past hospitalizations (include surgeries, psychiatric or substance abuse treatment – use back of page if necessary):

Date	Reason	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking any medications now? ☐ Yes ☐ No. If yes, please list and include over-the-counter medications you take routinely.

Medication/ Dosage	How often?	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Result				
Very good	Good	Fair	Poor	Adverse Reaction

Do you take supplements or herbs routinely? ☐ Yes ☐ No If yes, please list:

Supplement/Herb	Dosage	How often?	Reason for Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had side effects/allergic reactions from taking medication?
☐ Yes ☐ No. If yes, please explain_____
_____
_____

Please tell us how much caffeine you consume:
Estimated daily consumption of coffee or tea _____ cups/day
Estimated daily consumption of soda or cola _____ ounces/day

Psychiatric/Substance Use Information

Please tell us about your family's history of alcoholism, substance abuse and psychiatric problems. Indicate which, if any, family members you either suspect has had difficulties in these areas and/or has received treatment for these problems.

Relationship	Problem (specify alcoholism, substance abuse or psychiatric)	Problem suspected or actually treated?
Grandparents	_____	_____
Mother	_____	_____
Father	_____	_____
Brother/Sister	_____	_____
Children	_____	_____
Spouse/Sig. Other	_____	_____
Other (who?)		

Do you have a history of IV drug use? ☐ Yes ☐ No

Do you drink socially? How often? _____ How much?_____

How old were you when you took your first drink? _____

Have you ever felt you needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Have you ever attended A.A., Al-Anon, or N.A.? ☐ Yes ☐ No

Have you ever had a D.U.I? ☐ Yes ☐ No If yes, how many? _____

Have you ever been arrested for a drinking or drug-related offense of any kind? ☐ Yes ☐ No
If yes, please explain: _____

		No Current Use		Current Use				
Substance Category	**Common Names (circle all that apply)**	**Never Used**	**Did Use But Quit**	**Less than once per mo.**	**1 – 4X per mo.**	**1 – 4X per week**	**1 or More X Per Day**	**Age First Used**
Tobacco/ Nicotine	Cigarettes Snuff Cigars Chewing Tobacco E-cigarettes		**Date:**					
Alcohol	Beer Wine Hard Liquor		**Date:**					
Cannabis or Synthetic Marijuana	Marinol Pot Hashish Grass Weed Hash Oil Reefer Ganja Joint Mary Jane Spice/K2 Kush		**Date:**					
Stimulants	Cocaine (Coke; Snow; Crack; Rock; Blow; Nose; Toot; White);Crystal Amphetamines; Speed; Crank Uppers; Dexedrine; Ritalin; Adderall Methamphetamine; Diet Pills		**Date:**					
Depressants	Tranquilizers; Sleepers; 'Ludes Benzos (Xanax; Valium; Klonopin; Ambien, etc.) Barbiturates; Downers		**Date:**					
Inhalants	Glue Gasoline Aerosols Amyl Nitrate Poppers Paint Thinners Rush Nitrous Whippets		**Date:**					
Narcotics	Heroin Smack Horse Morphine Methadone Darvocet Codeine Percodan Hydrocodone Tramadal Oxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch		**Date:**					
Hallucinogens	LSD Peyote Mescaline PCP Acid Mushrooms MDMA(Molly; "X"; Ecstasy) Bath Salts Love Drug		**Date:**					
Over-the-Counter Drugs	Cold Pills Diet Pills Cough Syrups No Doz Sleep Aids Purple Drank Mini Thins Yellow Jackets		**Date:**					

 Your Name_____