Consumer Name:_____	Date of Birth: _____
Insurance Number:_____	Medical Record #: _____

Jonadab S. Franco, LCSW, LISW-CP

DBA: 21st Century Counseling, PLLC

Client Intake Form

Please complete all information on this form and bring it to the first visit. *It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!*

Consumers Name: _____

Name of parent or guardian (if under 18 years old):

_____

**** The following questions are in reference to the patient *(not the patient's parent or guardian)*****

Age: _____ Birthdate: _____ Gender: ☐ M ☐ F

Marital Status: ☐ Single/Never Married ☐ Married ☐ Divorced ☐ Separated

☐ Widowed ☐ Domestic Partnership

Please list any children and ages: _____

Home Address: _____
(Street Number)

_____
(City) (State) (Zip Code)

Home Phone: _____ ☐ yes ☐ no
(okay to leave a message/text)

Cell/Other Phone: _____ ☐ yes ☐ no
(okay to leave a message/text)

Email: _____ ☐ yes ☐ no

Your e-mail address will also be used to create a patient portal account (okay to email a message)

How did you find out about Jonadab S. Franco, LCSW, LISW-CP: _____

Referred by (if any): _____

Consumer Name:_____	Date of Birth: _____
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Emergency Contact Information:

_____

(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling or psychiatric services:☐ yes ☐ no

If yes: _____

(Name) (Phone)

What are the problem(s) for which you are seeking help for you or your child?

1._____

2._____

3._____

What are your treatment goals? What do you want therapy to accomplish?

_____

_____

_____

_____

_____

Family Background and Childhood History

Please list any medical (both physical and mental health) conditions that exist within your family, as well as the family member with the condition:

_____

_____

_____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

_____

_____

_____

_____

Is there any history of suicide in your family? If so, please list:_____

Do you have any siblings? If so, please list with ages, identify as brother or sister (*do not list names)*:

_____

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Who do you turn to for support in your family?

_____

Were you adopted? ☐ Yes ☐ No Where did you grow up? _____

List your siblings and their ages:

_____

_____

What is your father's name? _____
What is your father's occupation? _____
What is your mother's name? _____
What is your mother's occupation? _____
Did your parents' divorce? ☐Yes ☐ No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him:

_____

_____

_____

Describe your mother and your relationship with her:

_____

_____

_____

How old were you when you left home?

_____

Has anyone in your immediate family died?

_____

Who and when?

_____

Developmental History

Did your mother had a difficult pregnancy with you? ☐ yes ☐ no

If yes, please explain:

_____

_____

Were you born ☐ premature or ☐ full-term? If premature, please report how many weeks: _____

How was your birth? ☐ Normal/Vaginal ☐ C-Section ☐ Breech or ☐ other: _____

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Has the child had problems with any of the following?
Smiling ☐ yes ☐ no. If yes, please explain: _____
Sitting up ☐ yes ☐ no. If yes, please explain:_____
Walking ☐ yes ☐ no. If yes, please explain:_____
Talking ☐ yes ☐ no. If yes, please explain:_____
Toilet training ☐ yes ☐ no. If yes, please explain:
_____
Bed-wetting ☐ yes ☐ no. If yes, please explain:_____

Health and Medical

Do you currently have a primary physician? ☐ yes ☐ no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ☐ yes ☐ no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name | Total Amount | Daily Dosage | Estimated Start Date
_____
_____
_____
_____
_____
_____
_____
_____
Current over-the-counter medications or supplements:
_____
_____

How would you describe your current physical health (please check one):

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Excellent

☐Allergies:_____ Current Weight _____ Height _____

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Please list any current medical conditions:

_____

_____

_____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____

_____

_____

_____

Please check from the following list any items that you have experienced recently:

☐ Loss of interest in previously enjoyed activities
☐ Overwhelming sadness
☐ Crying often or crying spells
☐ Feeling hopeless
☐ Overwhelming anxiety, panic, or worry
☐ Frequent physical complaints (headaches, stomachaches, etc)
☐ Significant change in weight
☐ Trouble falling asleep or staying asleep at night
☐ Hyperactivity or often act without considering alternatives
☐ Refusal to follow rules or direction, even when the request is reasonable
☐ Negative behaviors towards peers
☐ Negative behaviors towards adult authority figure
☐ Increase risky behaviors
☐ Racing or disorganized thought patterns
☐ Thoughts of suicide
☐ Irritability or anger
☐ Mood shifts
☐ Self -Mutilation
☐ Overindulgence in alcohol, recreational drugs, or sexual activity

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

**** If NO, skip to trauma history header ****

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

Consumer Name:_____	Date of Birth: _____
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What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?__
Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No
Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which ones? _____
Have you ever abused prescription medication? ☐ Yes ☐ No
If yes, which ones and for how long? _____
_____

Circle if you have ever tried the following:

☐Methamphetamine
☐Cocaine
☐Stimulants (pills)
☐Heroin
☐LSD or Hallucinogens
☐Marijuana
☐Pain killers (not as prescribed)
☐Methadone
☐Tranquilizer/sleeping pills
☐Alcohol
☐Ecstasy
☐Other _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History
How you ever smoked cigarettes? ☐ Yes ☐ No
Currently? ☐ Yes ☐ No How many packs per day on average? _____ How many years? _____
In the past? ☐ Yes ☐ No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ☐Yes ☐ No In the past? ☐ Yes ☐ No
What kind? _____ How often per day on average? _____ How many years? _____

Trauma History
Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No.

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Please describe when, where and by whom:

_____
_____
_____
_____
_____

Religious/Spiritual Information

Do you consider yourself to be religious? ☐ no ☐ yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐ no ☐ yes

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

Educational history

Highest Grade Completed? _____ Where? _____

What grade are you currently in? _____ School name: _____

Did you had to repeat a grade? ☐ yes ☐ no. If yes, what grade did you repeat? _____

Do you currently have an individualized educational plan, IEP or a 504 plan? ☐yes ☐ no

Did you ever have an Individualized Educational Plan (IEP) when you attended school? ☐ yes ☐ no

Did you ever had any special classes? ☐ yes ☐ no. If yes, please explain:

_____
_____

Did you displayed conduct or behavioral problems when you attended school? ☐ yes ☐ no. If yes, please explain what problem behaviors you had in the educational setting:

_____
_____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained?

_____

Occupational and Social

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

If working what is your current occupation: _____

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Do you enjoy your current profession? ☐ yes ☐ no

if no what would you change: _____

Please list any current legal troubles at this time, if any:

_____

_____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

_____

_____

_____

What do you view to be your strengths as a person?

_____

_____

_____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.

_____

_____

_____

Is there anything else that you would like us to know?

_____

_____

_____

Emergency Contact: _____ Telephone #: _____

Signature and Date:

_____

(Signature of the legal guardian if under age 18)

Pleaser return the completed Client Intake Form to:
Jonadab S. Franco, MSW, LCSW, LISW-CP at 304 E Greene Street, Rockingham, NC 28379 by the time of the initial appointment for services.