Turning Point
Professional Counseling Services

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Office (785) 628-3575 - Fax (785) 621-2257

Adult Intake Form

Today's Date: ________________ ***Office Use Only***:(DX) Axis I:______________
Axis II:______________

Identification

Your Name: ____ ____
First MI Last Jr, Sr, etc.

Date of Birth: ____________ Age: ____ Sex: _____ Social Security #: ______________

Home/Mailing Address: ____

City: ______________________ State: _______ Zip: ______________

Home Phone: __________________ Cell Phone: __________________

Permission to leave voice message: □ Yes □ No Permission to leave text message: □ Yes □ No

Marital Status: □ Single □ Married □ Divorced/Separated □ Widowed □ Other

Insurance Information

Insurance Company:______________________ Member ID:______________________

Insured's Name:________________________ Group ID:_________________________

Insured's Date of Birth:___________ Copay: □ Yes □ No Amount:$_________

Relationship to Patient: □ Self □ Spouse □ Parent/Guardian □ Other

BCBS Members Only:
Have you previously been seen by a counselor? □ Yes □ No Number of times/last date _________

Optional:

Employment

□ Full time □ Part time □ Not currently employed

Your current employer: ________________________________ Years of Service _______

Marital Relationship History

Spouse's name M:Married D:Divorced W:Widowed

1. ____
2. ____

Primary Care Physician

Clinic/doctor's name: ____

Phone: ____________________

This form is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.
Updated April 2018

Checklist of Concerns

Please mark all of the items below that apply.

- ☐ Abuse: verbal, emotional, physical, sexual
- ☐ Anger, hostility, arguing, irritability, temper outbursts, easily frustrated, aggression
- ☐ Alcohol, tobacco, drug use
- ☐ Anxiety, panic attacks, stress, stress management
- ☐ Attention, concentration, distracted, confusion, thought disorganization
- ☐ Career concerns
- ☐ Children, child management, child care, parenting, custody
- ☐ Chronic pain indicate where:____
- ☐ Depression, loneliness, sadness, crying, isolation, low-energy, loss of interest
- ☐ Failure, inferiority, guilty feelings
- ☐ Fears, phobias
- ☐ Financial or money issues, debt, impulsive spending, gambling
- ☐ Friendships, interpersonal conflicts
- ☐ Grieving, death, loss, coping
- ☐ Health, illness, medical concerns
- ☐ Legal matters, charges, suits
- ☐ Men's Issues
- ☐ Marital conflict, divorce, separation, distance/coldness, infidelity/affairs, remarriage
- ☐ Personal childhood issues
- ☐ Religious issues/spirituality
- ☐ Self-esteem
- ☐ Self-harm, punishing yourself: verbally, physically (scratching, cutting)
- ☐ Sexual issues, dysfunctions, conflicts, desire differences
- ☐ Sleep: too much, too little, insomnia, nightmares
- ☐ Suicidal thoughts or actions
- ☐ Traumatic event
- ☐ Weight and diet issues, overeating, under eating, appetite, vomiting
- ☐ Women's issues
- ☐ Other concerns or issues:

____

Which concern would you most like help with:

____

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