CLIENT INTAKE FORM - ADULT

Please print clearly. **Today's Date:** _____ / _____ / _____

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** ____ **Zip:** _____ **Gender:** ☐ **Male** ☐ **Female**

Home Phone: ( ) _____ - _____ **Birthdate:** _____ / _____ / _____

Work Phone: ( ) _____ - _____ **Clinician's Name:** _____

Cell Phone: ( ) _____ - _____ **Referred By:** _____

Email Address: _____ **Responsible Party:** _____

May we leave messages identifying our agency? **Yes** ☐ **at home** ☐ **at work** ☐ **on cell phone** **OR** **No**

Marital Status: **Single** **Married** **Widowed** **Other** **Employer:** _____

Insurance Carrier: _____

Primary Insured's Name: _____ **Birthdate:** _____/ _____ / _____

Primary Insured's Address: _____

Primary Insured's Phone:( ) _____ - _____

NOTE: If insurance is filed by Groff & Associates, all **standard billing rates** must apply. If you are paying a reduced rate and try to file an insurance claim on your own, it constitutes *insurance fraud* and we will not release the information needed by the insurance company to process the claim.

Over the last two weeks, how often have you been bothered by the following problems?	**Not at all**	**Some Days**	**More than half the days**	**Most every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or let your family down	0	1	2	3
7. Trouble concentrating on things like reading the newspaper or watching television	0	1	2	3
8. Moving or speaking slowly that people have noticed	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Column Totals Questions 1 - 9 _____ **Column Totals Questions 10 - 16** _____

Based on the above challenges, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**