

PATHWAYS FORENSIC & MENTAL HEALTH SERVICES, PLLC

Mailing Address: 103 Wildlife Lane, Lufkin, TX 75904

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Adult Client Intake Form

CLIENT INFORMATION (Person receiving services)

Name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers *with area code*: Home: (____) _____

Email address: _____

Work Phone: (____) _____ Cell: (____) _____

Birth date: _____ Age: _____ Social Security Number: _____ - _____ - _____

Emergency Contact: _____ Phone: _____

EMPLOYER INFORMATION

Employer: _____

Position/Grade: _____ For how long? _____

Education Level: _____

Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ Policy Holder DOB _____

Relationship to Client _____

FAMILY INFORMATION:

Marital/relationship status: _____ Single _____ Married _____ Divorced

_____ Separated _____ (if separated / divorced, how long) _____ Widowed

Spouse/Significant other's name: _____

Please list all current or past health problems, and any major operations:

Current	Past

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital name/address	Date	Reason

MENTAL AND EMOTIONAL HEALTH

Have you ever been in counseling/therapy for any reason? (Circle one) YES NO

Counselor name/address	Date	Reason

Are you currently seeing any other therapist? YES NO

If so, name: _____

Reason for Current Treatment :

Have you ever **considered suicide**?

- in connection to your **current** problems? (Circle One) YES NO

If yes, please describe when and what you considered: _____

- in the **past**? (Circle One) YES NO

If yes, please describe when and what you considered: _____

Have you **attempted** suicide recently or in the past? (Circle One) YES NO

If yes, please describe when and what you tried: _____

Have you had any thoughts of **hurting others**?

- recently or in regard to your **current** problems? (Circle One) YES NO

If yes, please explain: _____

- in the **past**? (Circle One) YES NO

If yes, please explain: _____

CURRENT		PAST	
Very Unhappy	Abuse Victim	Very Unhappy	Abuse Victim
Short Attention Span	Behavioral Problems	Short Attention Span	Behavioral Problems
Grief	Lethargic, No Energy	Grief	Lethargic, No Energy
Impulsive	Suicidal Thoughts	Impulsive	Suicidal Thoughts
Mood Swings	Lying	Mood Swings	Lying
Fearful	Sleeping Problems	Fearful	Sleeping Problems
Irritable/Angry	Low Self-Esteem	Irritable/Angry	Low Self-Esteem
Self-Mutilating	Withdrawn	Self-Mutilating	Withdrawn
Parenting Issues	Eating Problems	Parenting Issues	Eating Problems
Anxious	Divorce	Anxious	Divorce
Intrusive Thoughts	Panic Attacks	Intrusive Thoughts	Panic Attacks
Trauma	Intimacy Issues	Trauma	Intimacy Issues
Worried	Hallucinations/Delusion	Worried	Hallucinations/Delusion
Alcohol Use	Excessive Crying	Alcohol Use	Excessive Crying
Relationship Issues	Trust Issues	Relationship Issues	Trust Issues
Temper Outburst	Educational Issues	Temper Outburst	Educational Issues
Drug Use		Drug Use	

What, if any of these problems/symptoms/ situations do you want or need to address?

SUBSTANCE USE/ABUSE HISTORY

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

Is your counseling court-related? _____ YES _____ NO

(If no, please skip the next section)

COURT-RELATED CLIENTS:

Please indicate which of the following applies to you: I am currently involved in:

_____ pre-Trial Criminal Case Charge: _____

_____ pre-Sentence Status Charge: _____

_____ Post-Conviction Criminal Case: Charge: _____

_____ Family Law Litigation Pending Court Action: _____

Attorney's Name: _____, Address: _____

List the charge(s) for which you are on probation, parole, or any charges still pending in the Court	Date of arrest	Probation Officer	

Please provide details below:

What are your primary goals for therapy? _____

I hereby consent for Pathways FMHS to provide evaluation and treatment services and release diagnostic codes and sessions dates to insurance if needed for billing purposes.

Client

Date

Continue to next page for final consents

GENERAL CONSENT FOR USE OF ELECTRONIC MEDIA:

My email address: _____

May we email you at this address: ___ YES ___ NO

My Home Phone Number: _____

May we leave messages at this number? ___ YES ___ NO

My Cell Phone Number: _____

May we leave messages on this number? ___ YES ___ NO

May we text you at this number? ___ YES ___ NO

By my signature, I am acknowledging that I have been made aware that Pathways Forensic & Mental Health Services is not using a private / encrypted server for the exchange of email; therefore, any use of email on my part to Pathways FMHS, or that of the therapist regarding my treatment, may be transmitted through a server that is not secure; therefore, may not be confidential. If you answer "Yes" to communicate by email, and/or text, you must sign this acknowledgement and consent.

With my signature, I am acknowledging that I have read and understand this disclosure and do, hereby, authorize Pathways to contact me in the manners designated above.

Client (or Parent/Guardian of Minor)

Date: _____