

***Courtney James, MSW, LCSW
2505 South 17th St, Suite 200
Wilmington, NC 28401
(910) 254-4545***

Dear Client:

I am excited to be working with you soon. Enclosed are several forms that need to be completed *prior* to your initial appointment.

The following forms are included within this packet:

1. Background History Form
2. Consent for Services (Includes Billing/Insurance Paperwork)

Please **complete and return** these forms to the following address *as soon as possible* by email to cjames.msw.lcsw@gmail.com, fax to 910-254-4557, or mail to:

*Potentials
Attn: Courtney James
2505 S. 17th St, Suite 200 Wilmington,
NC 28401*

If you are unable to send the intake packet prior to your Initial Interview/Intake Session; please ensure that you bring this document and Consent for Services completed to you first session.

If any questions or concerns arise as you complete these forms, please call my office staff at **910-254-4545**. I look forward to seeing you soon!

Courtney James, MSW, LCSW

Intake Packet for Adult Therapy Clients

Background Information Form

The purpose of this questionnaire is to gather information about you before your intake appointment. Along with the intake appointment itself, your answers to this form will assist your therapist in planning therapy to address your specific needs. Do not worry if you do not have all the information to answer every question, as we will be discussing this further at your intake appointment. Your time and effort in completing this background form is greatly appreciated!

General Information

Date: _____ Form Completed By: _____ Relationship to Client: _____

Name:

(First) (Middle) (Last) ("Nick Name")

Date of Birth: _____ Sex: _____

Best email address to contact you: _____.

Reason(s) for Current Appointment

Who recommended or referred you for this appointment?

What questions or concerns would you like addressed/answered?

What do you feel led to/caused these concerns? _____

When did you first notice these concerns? _____

Are you currently enrolled in school? Yes No If yes, please list where, and describe the program/degree you are seeking and your progress:

Tics									
Depression									
Anxiety									
Panic Attacks									
Obsessive-Compulsive Disorder									
Hearing Loss									
Vision Problems									
Other: _____									

Health and Medical History

Who is your primary care physician? _____

Have you had a medical check-up within the last 12 months? _____

Do you have any chronic or serious health problems? Yes No If so, please state _____

Have you had any surgeries or procedures? If yes, what surgeries or procedures and why? _____

What medications are you currently taking? _____

Have you ever been given a mental health/psychological diagnosis (e.g., anxiety, ADHD)? If so, please state diagnosis or diagnoses:

Developmental History

Were you delayed in meeting any major developmental milestones? Yes No If yes, state which milestone(s) were delayed and note whether you were just a little slower than typical or if there was a significant delay:

School History

What schools have you previously attended?

What were/are your academic strengths? _____

In what areas did you have more difficulty? _____

Did you ever repeat a grade? Yes No

Did you receive extra school help? Yes No

Social and Behavioral History

Do you have difficulties relating socially to others? Yes No

If yes, please describe _____

How easily do you make friends? Worse than average Average Better than average

What are your main hobbies or interests? _____

Please list things you do well: _____

What are your most positive features? _____

Do you have difficulty controlling certain bad habits? Yes No

If yes, please describe _____

Do you have excessive worries and/or fears?

If yes, please describe _____ Yes No

Have you ever been arrested/charged with a crime (other than a minor traffic violation)?

If yes, please explain _____ Yes No

Have you been in therapy/counseling before? If

yes, how positive of an experience was it for you? Yes No

