Juneau County Department of Human Services
Outpatient Counseling Services Pre-Intake: Adult

Form Completed by: _____ Date: _____

Relationship to person if other than self (spouse, relative, friend, etc.): _____

GENERAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____
Street, City, State, ZIP Code

CONTACT INFORMATION

Primary Number: _____ Secondary Number: _____
☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell

Email Address: _____

INSURANCE INFORMATION

Primary Insurance
Name of Policyholder: _____ Policyholder's DOB: _____

Insurance Company: _____

ID #: _____ Group #: _____

Secondary Insurance
Name of Policyholder: _____ Policyholder's DOB: _____

Insurance Company: _____

ID #: _____ Group #: _____

DEMOGRAPHIC INFORMATION

Gender: _____ Preferred Pronouns: _____

Race: ☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Veteran: ☐ Yes ☐ No

Your responses to the following questions will help determine which provider may best meet your needs. Incomplete sections may delay assigning your case. If you need more space, please include additional paper.

What service(s) are you seeking?

☐ Mental Health Counseling ☐ Substance Use Treatment

☐ Mental Health Counseling with Psychiatry

☐ Mental Health Counseling with Substance Use Treatment

Why are you seeking services at this time? _____

_____

_____

_____

If you were referred for services, who referred you? _____

Who is your Primary Care Physician? _____

Facility: _____

Are you currently pregnant? ☐ Yes ☐ No ☐ NA

List all current prescription medications. Include name of medication, dose, and frequency.

_____

_____

_____

_____

_____

Do you have any allergies or medical conditions you feel we should be aware of? _____

_____

_____

Continue to next page.

What is your current mental health diagnosis? _____

_____

List all previous mental health/psychiatric counseling/services/hospitalizations. Include facilities, providers, and dates.

_____

_____

_____

_____

_____

Is there a history of ☐ emotional abuse, ☐ physical abuse, or ☐ sexual abuse?

Is there a history of suicidal thoughts? ☐ No ☐ Yes

If yes, have you had attempts? ☐ No ☐ Yes; how old were you? _____

What is your current drug of choice? _____

List all previous Substance Use Treatment services (detox, OWI, Medicated Assisted Treatment, etc.). Include facilities, providers, and dates.

_____

_____

_____

_____

_____

Are you currently on Probation or Parole? ☐ Yes ☐ No

If yes, who is your agent? _____

Continue to last page.

We can accommodate disabilities. Please let us know if you have specific needs.

Any other information or concerns you'd like your therapist to know to better serve you?

Thank you for taking the time to complete this pre-intake. The information provided will help determine appropriate services to meet your needs.

MANAGER/PROVIDER – please complete and return to Intake Clerk

Assigned to: _____

Intake Scheduled for: _____ at _____
Date Time