Louisiana Empowerment Services

Intake Form

Personal Information

Date: _______________
Last Name: ________________________ First Name: _________________________ M.I.: __________
Age: ______ D.O.B.: ______________ Gender: __________ Veteran: _____ Marital Status: ___________
Pregnant: ___________ IV Drug User: _____
Social Security #: _________________________ Medicaid #: ___________________________________
Bayou Health Plan Provider: ____

Guardians Name (If under age) ____
Street Address: ____
City: _______________________ State: ______ Zip Code: _______________________
Home phone: _________________________ Ok to leave a message: ______
Cell phone: ___________________________ Ok to leave a message: ______
Work phone: __________________________ Ok to leave a message: ______

Name of emergency contact: _______________________________________
Relationship to you: _____________________________
Address: _______________________________________
Home phone: _____________________ Cell/Work phone: ____________________________

Referral Source (how did you hear about counseling services from whom and what organization)
____

Mental Health Information

Have you ever been in counseling/therapy before: ______?
If yes did you find it helpful or effective: ______

Are you currently receiving mental health services: _______?
If yes, please list name of practitioner and type of services you are receiving:
____
List any previous hospitalizations, incarcerations, foster homes/group homes due to emotional problems and/or behavioral problems: ____
____
Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:
____
____
Have you ever or are you currently engaging in self harm? Currently: ________ Past: _________
Have you ever or are you currently contemplating suicide? Currently: ________ Past: _________
Have you ever or are you currently contemplating harming another person? Currently: ________
Past:_________

Have you ever attempter suicide: _______ If yes, please list date(s), method(s), and your age at time of attempt:____
____

Do you exhibit physical aggression (hitting, pushing, kicking, bullying, breaking items, holes in walls, screaming, ect.)? ____
Do you exhibit verbal aggression and/or intimidation (cursing, screaming, threatening, ect.)?
____
Do you exhibit dangerous behavior (playing with fire, runaway from home/sneaking out, playing with weapons, getting out of a moving car, ect.)? ____

Please check any applicable behaviors that have persisted for at least the last 3 months and add details.

Substance Abuse (alcohol, illegal drugs, abusing prescription drugs)
____
Truancy(missing /skipping school)_______________________________________
Anxiety (worries a lot, bites nails, problem sleeping, nightmares, bed wetting, chewing on things) ____
Depression (cries a lot, no interest in doing things, not many friends, sleeping or eating problems) ____
Suicidal /Homicidal (tried to kill self or someone else) _____________________
Odd/Strange Behavior/Hallucinations/Delusions(sees things that are not there, hearing voices, talking to self)____
Negative Effect on Social Life (not invited to parties/relative houses due to behavior, limited friends due to behavior) ________________________________

Pharmacy Information: *Name:* ____
Address: ____________________________________ *Phone Number:* _____________________________

Educational Information

Number of years of education completed: ______ Degree(s) achieved___________
Name of School: ____
Ever suspended? ________ If yes, how many times? ________
Ever expelled? ________ If yes, how many times? ________
Reason(s) for suspension/expulsion? ____
What kind of grades is your child making in school? ____

Notes:

Staff Completing Form Signature:__________________________________ Date: __________________