Lillybrook
In Times of Struggle, We Are Here

Readmission Intake Form

Chart#: _____

Please complete the following information:

Date_____

Client's name: First _____ MI _____ Last _____

Address_____ City _____ State ____ Zip code_____

Phone: Home_____ Cell _____ Work _____

Is this a new address since your last episode of treatment? Yes/No

Birthday_____ Age_____

Emergency contact_____ Phone_____

Relationship to client_____

Has your insurance changed since the last episode of treatment? Yes/No

If yes, please list new information:

Insurance company_____

Contract number_____ Group number_____

Please list any changes in the follow areas that have occurred since your last visit to Joe Lilly, LLC. (Please Circle Yes/No)

Yes/No Family Relationships/Marital Status (e.g. divorce, marriage, etc.) _____

Yes/No Education (e.g. graduation, change in grade, etc.) _____

Yes/No Employment (e.g. new or lost job, layoff, etc.) _____

Yes/No Health Status (e.g. new medical condition, sickness, etc.) _____

Yes/No Financial Status (e.g. bankruptcy, etc.) _____

Yes/No Legal Status (e.g. arrest, conviction, law suit, etc.) _____

Yes/No Alcohol and/or Drug Use (e.g. starting, stopping, change in amount used, etc.) _____

_____

Yes/No Other (*please describe*) _____

_____

Previous Therapist _____ New/Current Therapist _____

Please state the reason you are currently seeking services at Lillybrook Counseling Services:

_____

_____

What areas of your life are being affected by the above?

Social
__Unable to form or maintain friendships
__Withdrawal from family and friends (excessive desire to be alone)
__Increased conflict with others
__Loss of interest in social activities
__Phobia
__Poor social skills

Occupational
__Unable to maintain job
__Absenteeism
__Conflicts with co-workers
__Tardiness
__Reduced productivity
__Disciplinary action for poor performance
__Attachment problems

Academic
__Failing grades
__Skipping school
__Tardiness
__Detention
__Reduced productivity
__Homework problems
__Fighting/conflicts with students/teachers

Physical
__Decreased energy/fatigue
__Difficulty getting out of bed or insomnia
__Decreased/Increased appetite (circle one)
__Substantial weight loss or gain (circle one)
__Psychosomatic complaints (headaches, stomach aches, etc.)
__Frequent illness
__Bed wetting

Affective Distress
__Crying spells
__Anger/rage
__Feeling overwhelmed with emotions
__Mood swings
__Concentration problems

Affective Distress Continued
__Worrying that interferes with the ability to concentrate
__Memory problems
__Disorganized thoughts

Risk Assessment
__Suicidality
__Homicidality
__Drug/Alcohol use
__Unprotected sex
__Cutting/Self-injury

Have you received any other therapy, counseling, or psychiatric services since you last attended Lillybrook Counseling Services? Yes/No
If yes, please provide information pertaining to the type of services, when, where, and with whom: _____

_____

_____

Please list any past or current medications, dosages, and the prescribing physician: _____

_____

_____

_____

_____ _____

Client signature Date

_____ _____

Parent/Guardian signature (if minor) Date

****Document will be reviewed by therapist and noted during the readmission session.**

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