Revive Therapeutics
Repair · Recover · Thrive
(860) 494-3800

CLIENT ADMISSION FORM

Client Name:_____ Gender:_____

Date of Evaluation: _____ Date of Birth:_____

Reason for seeking counseling including background information:_____

_____

_____

Check current clinical symptoms:

O Addictive Behavior
O Aggression/Violence
O Alcohol/Substance Abuse
O Alcohol/Substance Dependence
O Anger/Irritability
O Anxiety/Panic
O Appetite Problems/Restricting Intake
O Binge Eating w/o Compensatory Behaviors
O Binging/Purging
O Bizarre Behavior
O Chronic Medical Problems
O Depression
O Destructive Behavior
O Gender Identity Concerns
O Grief/Loss
O Homicidal Ideation
O Isolation/Withdrawal
O Mood Swings
O Obsessions/Compulsions
O Phobia/Fear
O Poor Impulse Control
O Post Traumatic Stress
O Problems Thinking/ Concentrating
O Self-Harming Behaviors
O Sexual Activity Concerns
O Sexual Identity Issues
O Sexual/Intimacy Issues
O Sleep Disturbance
O Stress/Feeling Overwhelmed
O Suicidal Ideation
O Tearful/Crying Spells

Check current psychosocial and environmental concerns:

O Academic/Educational Problems
O Acculturation Difficulty
O Bereavement
O Career/Job Dissatisfaction
O Communication/Trust Problems
O Disruption of Family by Separation/Divorce
O Domestic Violence
O Exposure to Disaster, War or Other Hostilities
O Family Relationship Conflict
O Financial Stressors/Hardship
O History of Military Deployment
O Homelessness
O Housing Problems
O Intense Family Distancing
O Legal Problems or Problems Related to the Legal System
O Parenting Issues
O Perpetrator of Abuse
O Phase of Life Problems
O Physical Impairment
O Problem Related to Current Military Deployment Status
O Religious/Spiritual Issues
O Target of Adverse Discrimination/Persecution
O Victim of Abuse
O Victim of Crime

If client is under 18, check current symptoms below in addition to those above:

O Aggression
O Autism Spectrum Disorder
O Bed Wetting
O Blended Family Issues
O Destruction of Property
O Divorce/Separation
O Fire Setting
O Hyperactivity
O Inattention
O Impulse Control Issues
O Learning Disorder
O Lying/Manipulative Behavior
O Night Terrors
O Oppositional Behavior
O Perpetrator of Bullying
O Risk-Taking Behavior
O Running Away
O School Problems
O Separation Anxiety
O Stealing
O Tantrums
O Unusual birth/pregnancy events
O Victim of Abuse/Neglect
O Victim of Bullying

Previous Treatment: O Yes O No

If yes, please indicate dates, whether inpatient/outpatient, problem for which you were treated, and name of treating professional:

Please list any allergies/drug sensitivities: _____

Indicate Current Medications and Dosage: _____

Name and Phone Number of Prescribing Professional: _____

If not on medication, is a referral for a medication evaluation needed? O Yes O No

Name and Phone # of Primary Care Physician: _____

Permission to contact Primary Care Physician regarding treatment: O Yes O No

Please list past & present tobacco, alcohol, and drug use: _____

List Strengths/Accomplishments: _____

Client Signature _____ Date _____