STANDARD INTAKE FORM ADULT ONLY

Client Name _____

Client Address _____

TOTAL LIFE CHANGE COUNSELING

1800 Gurnee Ave Anniston AL, 36201-3731

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can:

_____

_____

_____.

What are your goals for counseling?

_____

_____

_____.

Have you seen a mental health professional before?

☐ Yes ☐ No

Specify all medications and supplements you are presently taking and for what reason.

_____

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

_____

Who is your primary care physician? Please include type of MD, name and phone number. _____

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you have suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Do you have thoughts or urges to harm others? ☐ No ☐ Yes

Have you ever been hospitalized for a psychiatric issue? ☐ Yes ☐ No

Is there a history of mental illness in your family? ☐ Yes ☐ No

If you are in a relationship, please describe the nature of the relationship and months or years together.

_____

Describe your current living situation. Do you live alone, with others. With family, etc...

_____

_____.

What is your level of education? Highest grade/degree and type of degree. _____

What is your current occupation? What do you do? How long have you been doing it? _____

Please check any of the following you have experienced in the past six months

☐ Increased appetite ☐ Decreased appetite ☐ Trouble concentrating

☐ Difficult sleeping ☐ Excessive sleep ☐ Low motivation ☐ Isolation from others

☐ Fatigue/low energy ☐ Low self-esteem ☐ Depressed mood ☐ Tearful or crying spells

☐ Anxiety ☐ Fear ☐ Hopelessness ☐ Panic ☐ Other

Please check any of the following that apply

☐ Headache ☐ High blood pressure ☐ Gastritis or esophagitis ☐ Hormone-related problems ☐ Head injury ☐ Angina or chest pain ☐ Irritable bowel ☐ Chronic pain

☐ Loss of consciousness ☐ Heart attack ☐ Bone or joint problems ☐ Seizures

☐ Kidney-related issues ☐ Chronic fatigue ☐ Dizziness ☐ Faintness

☐ Heart valve problems ☐ Urinary tract problems ☐ Fibromyalgia

☐ Numbness & tingling ☐ Shortness of breath ☐ Diabetes ☐ Hepatitis

☐ Asthma ☐ Arthritis ☐ Thyroid issues ☐ HIV/AIDS ☐ Cancer ☐ Other

What else would you like me to know?

_____

_____.