ADULT INTAKE INFORMATION FORM

Client Name: ______________________________ Date: ______________

Gender: Female ______ Male ______ Date of Birth: __________________ Age: ________

SSN: __________________________ DL: __________________________

Form completed by (if someone other than client): __________________________

Primary reason(s) for seeking services (Please check the following that applies):

_____ Marital Problems
_____ Parenting
_____ Relationship
_____ Family
_____ Anger Management
_____ Anxiety
_____ Coping
_____ Depression

_____ Eating Disorder
_____ Fear/Phobias
_____ Mental Confusion
_____ Sexual Concerns
_____ Sleeping Problems
_____ Addictive Behaviors
_____ Alcohol/Drugs
_____ Eating Habits

_____ Job
_____ Medical/Health Problems
_____ Other Mental Health Concerns (Specify)

____

____

____

Marital Status: (More than one answer may apply)

_____ Single

_____ Divorce in Process
Length of Time: _______________

_____ Unmarried, Living Together
Length of Time: _______________

_____ Legally Married
Length of Time: _______________

_____ Separated
Length of Time: _______________

_____ Divorced
Length of Time: _______________

_____ Widowed
Length of Time: _______________

_____ Annulment
Length of Time: _______________

Total Number of Marriages:
____

Religious/Cultural/Ethnic:

Are you experiencing any problems due to cultural or ethnic issues? Yes ______ No ______

If yes, to which cultural or ethnic group do you belong?: __________________________

Please describe the issue: __________________________

Other cultural/ethnic information: __________________________

Would you like your spiritual/religious beliefs incorporated into your counseling? Yes ______ No ______

If yes, describe: __________________________

Do you have a religious affiliation? Yes ______ No ______

If yes, describe: __________________________

Legal:

Are you involved in any criminal proceedings or litigation at the present time? Yes ______ No ______

If yes, describe: __________________________

Are you presently on probation or parole? Yes ______ No ______

If yes, describe: __________________________

Education:

Level of education completed:

_____ GED
_____ High School
_____ Some College
_____ Associate
_____ Bachelor's
_____ Master's
_____ Doctorate
_____ Other: ______________________

Currently enrolled in school? Yes ______ No ______

If yes, where: ______________________

Special circumstances (e.g., learning disabilities, gifted): ______________________

Military:

Military experience? Yes ______ No ______ Combat experience? Yes ______ No ______

Where: ______________________

Branch: ______________________ Discharge date: ______________________

Type of discharge: ______________________

Family Information:

RELATIONSHIP	NAME	AGE	LIVING		LIVING WITH YOU	
Mother	______	______	Yes ______	No ______	Yes ______	No ______
Father	______	______	Yes ______	No ______	Yes ______	No ______
Spouse	______	______	Yes ______	No ______	Yes ______	No ______
Children (1)	______	______	Yes ______	No ______	Yes ______	No ______
Children (2)	______	______	Yes ______	No ______	Yes ______	No ______
Children (3)	______	______	Yes ______	No ______	Yes ______	No ______

Significant Others (e.g., brothers, sisters, grandparents, step-relatives/half-relatives). Please specify.

______	______	Yes ______	No ______	Yes ______	No ______
______	______	Yes ______	No ______	Yes ______	No ______
______	______	Yes ______	No ______	Yes ______	No ______
______	______	Yes ______	No ______	Yes ______	No ______

Medical/Physical Health: (Please check the following that applies):

_____ AIDS
_____ Alcoholism
_____ Abortion
_____ Anemia
_____ Bladder Control
_____ Cancer
_____ Chronic Pain
_____ Dizziness
_____ Diabetes
_____ Drug Abuse
_____ Epilepsy
_____ Eating Problems
_____ Fatigue
_____ Hepatitis
_____ Headaches/Migraines
_____ High Blood Pressure
_____ Mononucleosis
_____ Miscarriages
_____ Nausea
_____ Neurological Disorders
_____ Sexual Problems
_____ Sleeping Disorders
_____ Stomach Aches
_____ Sexually Transmitted Diseases
_____ Thyroid Problems
_____ Vomiting

Other (describe): ______________________________

List any current health concerns: ______________________________

List any recent health or physical changes: ______________________________

____

Current Prescribed Medications	Dose	Length of Time	Purpose	Side Effects

Current Over-the-Counter Meds	Dose	Length of Time	Purpose	Side Effects

Family history of medical problems: ______________________________

____

Please check if there have been any recent changes in the following:

_____ Sleep Patterns
_____ Eating Patterns
_____ Behavior
_____ Energy Level
_____ Physical Activity Level
_____ General Disposition
_____ Weight
_____ Nervousness/Tension

Describe changes in areas in which you checked above: ______________________________

____

Please tell us about your prior counseling and/or treatment history:

Family Information:	Yes	No	When	Where	Reason / Diagnosis
Counseling/Psychiatric Treatment	________	________	________	____________	______________________
Suicidal Thoughts/ Attempts	________	________	________	____________	______________________
Drug/Alcohol Treatment	________	________	________	____________	______________________
Hospitalizations	________	________	________	____________	______________________
Involvement with Self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	________	________	________	____________	______________________

Have any of your family members or significant others had counseling or treatment in any of the above areas?

____

____

Do you drink alcohol? Yes ______ No ______

If yes, how often and in what quantity? ____

____

Have you used/abused drugs, alcohol or controlled substances? Yes ______ No ______

If yes, please explain: ____

____

Does/Has someone in your family have/had a problem with drugs or alcohol? Yes ______ No ______

If yes, please describe: ____

____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes ______ No ______

If yes, describe: ____

____

Have drugs or alcohol created a problem for your job/relationship? Yes ______ No ______

If yes, describe: ____

____

Behavioral History:

Please check behaviors and symptoms that are problematic for you:

_____ Aggression
_____ Alcohol Dependence
_____ Anger
_____ Anemia
_____ Hallucinations
_____ Anxiety
_____ Avoiding People
_____ Chest Pain
_____ Cyber Addiction
_____ Depression
_____ Disorientation
_____ Distractibility
_____ Dizziness
_____ Drug Dependence
_____ Eating Disorder

_____ Phobias/Fears
_____ Fatigue
_____ Gambling
_____ Sexual Addiction
_____ Heart Palpitations
_____ High Blood Pressure
_____ Hopelessness
_____ Impulsivity
_____ Irritability
_____ Judgment Errors
_____ Loneliness
_____ Memory Impairment
_____ Mood Shifts
_____ Hyperactivity
_____ Panic Attacks

_____ Pornography
_____ Disruptive Thoughts
_____ Spending Problems
_____ Sexual Difficulties
_____ Sleeping Problems
_____ Speech Problems
_____ Suicidal Thoughts
_____ Disorganized Thoughts
_____ Trembling
_____ Withdrawing
_____ Worrying
_____ Social Problems
_____ Other (Specify):
____
____

Briefly discuss how the above symptoms impact your ability to function: ______________________________
____
____
____

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

Yes ______ No ______

If yes, describe: ____
____
____

Stress Indicators:

Were there special, unusual, or traumatic circumstances that affected you in childhood? (i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss) Yes ______ No ______

If yes, please describe: ____
____
____

Please check any events that have occurred in the last 12 months:

_____ Moving

_____ Marriage

_____ Natural Disaster

_____ Divorce

_____ Car Trouble

_____ Job Change

_____ Financial Problems

_____ Birth of a Child

_____ Death of a Close Family Member/Friend

COUNSELING GOALS

What would you like to see accomplished in your counseling?

1. ____

____

____

2.____

____

____

3.____

____

____

4.____

____

____