Adult Intake Form

Name: _____ Age: _____

Referred by: _____

Presenting Concerns

Describe the concerns that bring you to counseling: _____

_____

How long have you been experiencing these concerns? _____

What have you done to address these concerns? _____

Any other concerns? ☐ family ☐ marital ☐ work ☐ legal ☐ money ☐ school ☐ social

☐ other _____

What are your goals for services? _____

_____

Living Situation

List those who live with you: Relationship to you:

_____ _____

_____ _____

Do you have children? ☐ yes ☐ no If so, please list: Names: Age:

_____ _____

_____ _____

_____ _____

_____ _____

Family Information

How would you describe your childhood? ☐ good ☐ fair ☐ poor Explain: _____

_____

Were your parents ever divorced or separated? ☐ yes ☐ no If yes, how old were you? _____

How many sisters do you have? _____ How many brothers? _____ Where are you in the birth order? _____

Is your mother living? ☐ yes ☐ no Mother's age _____ Is your father living? ☐ yes ☐ no Father's age: ___

Describe your relationships with your parents/siblings (if applicable): _____

_____

Has any member or your immediate family been diagnosed with a mental illness? ☐ yes ☐ no

Who? ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Uncle ☐ Aunt

Please Describe: _____

Were you ever abused/neglected as a child? ☐ yes ☐ no

If yes, was it: ☐ physical abuse/neglect ☐ emotional abuse/neglect ☐ sexual abuse

Who abused/neglected you? _____

Were there any substance abuse problems in your family when you were growing up? ☐ yes ☐ no

Explain: _____

Did you attend church as a child? ☐ yes ☐ no If so, what religion? _____

Marital Status: ☐ never married ☐ married ☐ separated ☐ divorced ☐ widowed

If you've been married, how many times? _____ If currently married, how long? _____

If not married, are you in a relationship? ☐ yes ☐ no How long in this relationship? _____

Are you currently satisfied with your relationship? ☐ yes ☐ no Explain: _____

Have you ever been abused in any of these relationships? ☐ yes ☐ no Explain: _____

Social Supports

Who/what do you consider your support system? _____

What meaningful activities are you involved in (or would like to be)? _____

Are you involved in religious/spiritual activities? ☐ yes ☐ no

Current religious preference: _____

Legal History

Are you currently facing charges? ☐ yes ☐ no Explain: _____

Are you currently on probation, parole or work release? ☐ yes ☐ no

Name of probation officer: _____

Number of arrests related to alcohol/drugs? _____ Number of arrests not related to alcohol/drugs? _____

Education

Highest grade you have completed: _____ Where? _____

Do you attend school now? ☐ yes ☐ no What school? _____

Did you have problems in school? ☐ yes ☐ no Describe? _____

How would you describe your school experience: ☐ good ☐ fair ☐ poor Explain: _____

Employment

Do you work? ☐ yes ☐ no Where? _____

How many hours a week? _____ How long at this job? _____

Do you have problems at work? ☐ yes ☐ no Describe: _____

Comments about work history: _____

_____

Describe your income: ☐ Upper ☐ Middle ☐ Low

Do you have adequate income for food and housing? ☐ yes ☐ no

Trauma History

Have you ever experienced or been a witness to an extremely stressful event? ☐ yes ☐ no

Explain:_____

_____

Mental Health Symptoms (Please check all that apply):

Current	Past		Current	Past		Current	Past	
		Depressed mood			Excessive Talking			Feel guilty or worthless
		Anger outbursts			Racing thoughts			Fear of social situations
		Not enough sleep			Easily distracted			Repetitive thoughts/behavior
		Too much sleep			Self-harm			Thoughts of death or suicide
		Fatigue			Impulsive behavior			See/hear things that aren't real
		Irritability			Recent loss/grief			Work/school problems
		Never tired			Financial problems			Violent thoughts/behaviors
		Cannot concentrate			Tense/unable to relax			Lost or gained weight
		Afraid to leave home			Excessive worry			Relationship problems
		Inflated self-esteem			Panic attacks			Careless, high risk behavior
		Unreasonable fear			Upsetting memories			Suspect things that may not be real

Any other symptoms not listed?_____ What age did symptoms begin?_____

Medical

Please list any medical conditions that you are being treated for:

_____

_____

Physician Name: _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ normal weight

By how many pounds? _____ How has your weight changed in the past six months? _____

Are you on any special diet? ☐ yes ☐ no Explain: _____

Do you have concerns with: ☐ nausea ☐ binge eating ☐ not eating

☐ excessive exercise ☐ diet pills/laxatives ☐ purging (purposeful vomiting)

Have you ever experienced a head injury? Describe: _____

Substance Use

Do you use drugs? ☐ yes ☐ no What drugs? _____

Do you use alcohol? ☐ yes ☐ no Ever been through treatment? ☐ yes ☐ no If yes, when: _____

How often? ☐ daily ☐ 4-6 days/week ☐ 1-3 days/week ☐ few times/month ☐ less

Do you ever experience memory lapses or blackouts after using alcohol or drugs? ☐ yes ☐ no ☐ occasionally

Does alcohol or drug use effect your social life or work? ☐ yes ☐ no ☐ occasionally

Do you ever gamble more money than you intend to or can afford? ☐ yes ☐ no ☐ occasionally

Prior Treatment

Have you ever been in counseling before? ☐ yes ☐ no When? _____

Where?_____

Have you ever been in a psychiatric hospital before? ☐ yes ☐ no When? _____Where? _____

Reason? _____

What was helpful with past treatment? _____

What was not helpful with past treatment? _____

Medications (MEDICATION TAKEN AT PRESENT TIME):

Drug	Dosage/Frequency	Prescribed by	Reason

Safety

Have you had recent thoughts about: ☐ not wanting to live ☐ hurting yourself ☐ hurting someone else

☐ Not Applicable Comments: _____

Have you ever: ☐ made a suicide attempt ☐ injured yourself on purpose ☐ overdosed on purpose or accident

☐ Not Applicable Comments: _____

Please list any other safety concerns: _____

Have you had any significant losses in the past 2 years? _____

Do you have difficulty (past or present) with anger management? ☐ yes ☐ no

Explain: _____.

Life Goals, Strengths, and Barriers

Describe your life goals: _____

_____

What strengths/abilities/skills do you have that help you reach your goals? _____

_____

What barriers are there to your success? _____

What has allowed you to achieve past desired goals?

_____

Thank you for taking the time to fill out this questionnaire.
The information is valuable and saves us time in session with you!