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Adult Intake Forms

Name: _____ Today's Date: _____

DOB: _____ Age: _____

Address: City: ST: Zip: Mailing Address (if different):

Phone: (C) (H) (W)

Email:

May we leave a voice/text message? Yes ☐ No ☐ If yes, by ☐ cell ☐ home ☐ work ☐ email May we send you an appointment reminder? Yes ☐ No ☐ If yes, by ☐ text ☐ v-mail ☐ email

Employer: Occupation:

Are you a student? Yes ☐ No ☐ If yes, name of school:

Emergency Contact: Relationship: Phone: Referred by: May we send them a thank you? Yes ☐ No ☐

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling:

When did these problems or issues develop?

What are you hoping to achieve through counseling?

Client Problem Assessment

Presenting Problem – Precipitating Stressors: “In recent months, I have been concerned about...” *Please check all that apply, past or present*

☐ Marriage ☐ Spouse/Partner ☐ Parent/Child ☐ Family of Origin ☐ Extended Family ☐ Abuse (☐ physical
☐
sexual ☐ psychological ☐ neglect) ☐ Guilt ☐ Shame ☐ Cultural/Ethnic/Race ☐ Health ☐ Job ☐ Financial

Other:

Symptoms *Please check all that apply:*

☐ Decreased Concentration ☐ Decreased Motivation ☐ Decreased Energy ☐ Disturbance in Sleep
Patterns ☐ Increased Stress ☐ Loss of Control ☐ Decreased Interest in Activities ☐ Numbness or Tingling
☐ Chest Pains /

Discomfort ☐ Unexplained Physical Problems ☐ Body Tension ☐ Thoughts of Death/Suicide Other Major Life Events *Please check all that apply:*

☐ Death of a family member/friend ☐ Divorce ☐ Separation ☐ Imprisonment ☐ Personal injury/illness ☐ Marriage ☐ Job loss ☐ Pregnancy/complications ☐ Career change ☐ Legal problems ☐ Relocation ☐ Holidays ☐ Financial Other:

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes ☐ No ☐ Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ☐ No ☐ Are you presently suicidal/homicidal? Yes ☐ No ☐

If yes, explain (*how, when, where, what method, why*):

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ☐ No ☐ Have you ever subjected another person to physical harm? Yes ☐ No ☐

If yes, explain (*how, when, where, what method, why*):

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses. Strengths

Weaknesses

Living Arrangements

Current Address: How Long: With whom do you live? Current relationship with others where you live:

Relationship History Sexual Orientation:

Are you married? Yes ☐ No ☐ If not married, are you in a relationship? Yes ☐ No ☐ Name and age of spouse/partner:

Date of marriage/cohabitation:

Previous marriage/relationship: Yes ☐ No ☐ If yes, name of spouse/partner:

If yes, date of divorce/end of partnership: Where children involved in the previous marriage/partnership:

Yes ☐ No ☐ What is your perception of the status of your *current* relationship? *(include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.)*

Name, ages, and relational history of children from marriages/partnerships.

Name Age Comments Bio, Step, Adopted

Developmental History

List the members of your family of origin/adoption and your compatibility with each one

What was your birth order: # of children. Who primarily raised you? How would you describe your childhood? ☐ Uneventful ☐ Boring ☐ Traumatic ☐ Painful ☐ Unhappy ☐ Ignored ☐ Neglected ☐ Withdrawn ☐ Other

What was life like for you as a child? *(Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)*

Did you experience any traumatic events as a child or adult? *(Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)*

Date Age Event

Support System

Who do you depend on for support? *(Check all that apply)*

☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Employer ☐ Church ☐ Pastor ☐ Therapist ☐ Extended

Family ☐ Neighbor(s) ☐ Close Friend(s) ☐ Co-Worker(s) ☐ Doctor(s) ☐ Support Group(s) ☐ Community Services ☐ Other:

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes ☐ No ☐ If yes, explain who and why (*complete release of information consent form if needed*):

Legal History (*Please explain all that apply, past and present*) Charges as a minor:

Current Charges:

Arrests:

Convictions: Parole/Probations: Bankruptcies: Divorce/Separation: Foreclosures:

Civil Suits:

Financial Situation

Briefly describe your financial situation:

Work History

Describe your current job/career:

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

Have you ever been fired from a job? Yes ☐ No ☐ If so, please explain: Educational History

Describe what school was like for you:

Highest level of education: What kind of grades did you make?

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background:

Do you have a religious/spiritual background? Yes ☐ No ☐ Preference

Do you attend religious/spiritual services? Yes ☐ No ☐ If so, where and how often?

Medical History

How would you describe your current health?

Name of Medication Dosage/Frequency Prescribing Physician

Has it been more than a year since your last physical exam, including blood work? Yes ☐ No ☐ Have you had or were you involved with an abortion? Yes ☐ No ☐ Miscarriage? Yes ☐ No ☐ List previous health issues including surgeries, procedures, and medical hospitalizations:

Psychiatric History (Please list all previous inpatient / outpatient experiences.)

Have you ever been treated by a psychiatrist/psychologist for a mental health issue?

Have you ever been hospitalized for mental health related issues? Yes "No"

Have you ever been hospitalized for mental health issues related to substance abuse? Yes "No"

..

If you answered yes to any of the above, please provide as much information as possible. Date(s)
Provider reason for Treatment Results List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep:

Has anyone in your family ever been diagnosed or treated for a mental health disorder,

Substance Use / Abuse History Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

Substance Amount Frequency Age of 1st use -Age regular use started -Age last used

Have you experienced an increase in the use of alcohol and/or other substances? Yes "No "

Do you see your usage as a problem? Yes "No "

If so, when did it become problematic? Please describe any previous experience with substances or alcohol Please describe any family history of substance and/or alcohol use Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes "No "

If so, please describe

Additional Information Is there any other information that can be helpful for us to know about you?