VERITY
COUNSELING

Intake Information-Adult

Today's Date:_____ **Name**:_____ **Date of Birth**: _____

Preferred Name: _____ **Pronouns:** he/him/his, she/her/hers, they/them/theirs, other_____

Address:_____ **City/State:**_____**Zip**:_____

Social Security Number: _____ **Gender:** ☐ Male ☐ Female ☐Other_____

Telephone: (_____)_____ **Email Address:** _____

Permission to contact: Email ☐ Yes ☐ No Phone Call ☐ Yes ☐ No Text ☐ Yes ☐ No Mail ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Married (date)_____ ☐ Divorced (date) _____ ☐ Separated

☐ Domestic Partnership ☐ Widowed (date)_____ ☐ Other_____

Employer & Occupation:

_____

Please list additional family members or other individuals living with you:

Name	Relationship	Date of Birth	Employer/School

Are you currently receiving care for your mental health needs from a medical professional? ☐ Yes ☐ No
If YES, please fill in the following information:

Physician name: _____

Address:_____ Phone number: (_____)_____

Individual to contact in case of emergency: Name:_____

Relationship:_____ Phone number: (_____)_____

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Individual Concerns

Please answer any of the following questions that you think apply to the reason you are seeking counseling.

Circle the following terms that pertain to you or any of your family members. Indicate concerns for yourself with an "S" and concerns for family members with an "F".

Nervousness	Health Problems	Marital Problems	Drug Usage	Depression
Shyness	Stomach Problems	Divorce	Alcohol Usage	Nightmares
Bowel Problems/IBS	Anger	Separation	Financial Problems	No Ambition
Loneliness	Insecurity	Affair	Problems w/Friends	Rumination
Frustration	Headaches	Problems w/ ex-spouse	Can't Have Fun	Hormone Issues
Video Game Addiction	Memory Loss	Stress	Tiredness	School Problems
Self-Control	Sleeping Problems	Grief	Children	Weight Gain/ Loss
Autoimmune Disorders	Impulsivity	Parenting Problems	Career Choices	Temper
Fears	Anxiety	Relationship Problems	Problems w/Parents	Restricting Calories
Panic Attacks	Eating Problems	Legal Problems	Chronic Pain	Joblessness
Isolation	Suicidal Thoughts	Work Problems	Sexual Addiction	Trauma
Can't Concentrate	Lack of Energy	Pornography Usage	Gambling Addiction	Physical Violence

What is going on in your life that brings you to therapy?

_____

_____

_____

What kinds of stressors are you experiencing right now?

_____

_____

_____

_____

What important things about you would it be helpful for your therapist to know?

_____

_____

_____

_____

_____

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Physical and Emotional Health History

List any medical problems you currently have:

_____

List any previous diagnosis you, your parents or siblings have been given (designate who was given the diagnosis):

_____

_____

If you have noticed any <u>recent changes</u> in the following areas, <u>please circle those changes</u>

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking

B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

List all medication you are currently taking or have been prescribed:

_____

List any other counseling you or a member of your family are receiving or have received:

_____

Have you ever been physically/sexually/emotionally abused (Circle to indicate which one(s)? No Yes

If YES, briefly describe:_____

_____

Have you ever been hospitalized for mental or nervous problems? No Yes

If YES, when, where, and how long? _____

Have you ever attempted suicide? NoYes

If YES, when, where, and how? _____

Are you suicidal now? No Yes

Do you drink alcohol? No Yes **If YES**, how often? _____

Do you use drugs? No Yes **If YES,** what drugs do you use and how often? _____

_____

Have you ever been arrested? No Yes **If YES,** date(s) of arrest and reason? _____

_____

Are you currently involved, or do you expect to be involved in any court-related matters? No Yes

If YES, please describe _____

_____

What do you hope to accomplish in therapy?

_____

_____

By signing, you are stating that you answered all questions honestly and to the best of your knowledge:

Client signature: _____ Date: _____