CROSSVILLE COUNSELING CENTER

Adult Intake Form

Please print clearly. Please fill out form completely. Readmit: ___ Yes ___No
Date: ___________ **Client's Social Security #:**______________________ **Case #:** ______________
Client's *Legal* Last Name: _____________________ ***Legal* First Name:** _________________ **M.I.** ____
Address: __________________________________ **City:** _______________ **State:** ______ **Zip:** ______
Tel. (home) ______________________ (work)______________________ (cell) ___________________
OK to leave messages? Home: ___Yes ____No **Work:** ___Yes ___No **Cell:** ___Yes ___No
Email Address: ____ **Can Emails be sent:** __Y __N
Birthdate: ____/____/_____ **Age:**______ **Gender:** ___F ___M **Race:** _____________________
Highest level of education: ____
Name of Spouse/Guardian: _______________________________ **Phone:** _________________________
Address: ____________________________________ **City:**_______________ **State:** _____ **Zip:** _______

Emergency Information:
In case of emergency, contact:
Name (1) __________________________________ Relationship _________________ Phone ____________
Address ___________________________________ City _________________ State _____ Zip ________

Name (2) __________________________________ Relationship _________________ Phone ____________
Address ___________________________________ City _________________ State _____ Zip ________

Physician ____ Phone _______________________
Address ___________________________________ City _________________ State _____ Zip ________
Can your PCP be contacted for continuity of care, if needed: _____Yes ______Refused

Employment Information
Client/Guardian: Place _________________________________ Occupation ___________________ Hrs. ____
Spouse: Place _________________________________ Occupation ___________________ Hrs. ____

Insurance Information

Primary Insurance ____________________________
Contract/ID# ________________________________
Group/Acct# ________________________________
Subscriber __________________________________
Subscriber Social Security # ____________________
Subscriber Date of Birth _______________________
Client's relationship to Subscriber
___Self ___Spouse ___Son/Daughter

Secondary Insurance __________________________
Contract/ID# ________________________________
Group/Acct# ________________________________
Subscriber __________________________________
Subscriber Social Security # ____________________
Subscriber Date of Birth _______________________
Client's relationship to Subscriber
___ Self ____Spouse ____Son/Daughter

Referral Source
How did you hear of Crossville Counseling? ____
Address ______________________________________ City________________ State _____ Zip _________
Phone ______________________________________

Do you (client) have a __conservator __guardian ___representative payee ___personal representative
___No ___Yes If Yes, Name ____
Address____
Is someone coordinating your services (e.g. legal, mental health, physical)? ___No ___Yes
If Yes, Name ____
Address ___________________________________City __________________ State_____ Zip_______

Primary reason(s) for seeking services:

___Anger management ___Anxiety ___Coping ___Depression
___Eating Disorder ___Fear/phobias ___Mental confusion ___Sexual concerns
___Sleeping problems ___Addictive behavior ___Alcohol/drugs ___Past Trauma
___Other mental health or behavioral concerns (specify) ____________________________________

How old were you when you first felt these symptoms? _____________________________________

Any Additional information that would assist in understanding your concerns or problems? _________
____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___Aggression/Hostility
    ___Physical
    ___Verbal
___Panic Attacks
___Emotional Outbursts
___Alcohol abuse/dependence
___Anger
___Avoiding people
___Eating disorder
___Homicidal ideation
___Chest pain
___Speech problems
___Computer addiction
___Depression
___Trembling
___Difficulty getting along with
    ___Family
    ___Friends
___Low energy
___Memory Impairment
___Higher than usual mood
___Drug dependence
___Racing thoughts
___Fatigue
___Gambling
___Loneliness
___Heart palpitations
___High blood pressure
___Low self-esteem
___Hopelessness
___Judgment errors
___Impulsivity
___Irritability
___Behavior problems
___Difficulty with intimate relationships
    ___Initiating
    ___Sustaining
___Obsessions
___Paranoid
___Overly Sensitive
___Phobias/fears
___Rapid speech
___Recurring thoughts
___Sexual addiction
___Sexual difficulties
___Sick often
___Worrying
___Withdrawing
___Distractibility
___Disorientation
___Suicidal thoughts
___Thoughts disorganized
___Disruptive (home/school)
___Elimination problems
___Gender issues/identity
___Career conflict
___Other (specify)
____

Describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) ____
____

Stressors: (Check all that apply)

___Anticipated retirement ___Arrest ___Bankruptcy ___Becoming a parent
___Birth of first child ___Chronic illness ___Court trial ___Change in financial status
___Birth of a sibling ___Conflict w/boss ___Conflict w/child ___Conflict w/co-worker
___Breakup of relationship ___Conflict w/teacher ___Death of a child ___Death of a friend
___Change in residence ___Death of parent ___Death of spouse ___Death of grandparent
___Change of employment ___Financial difficulties ___Divorce ___Divorce of parents
___Change of school ___Engagement ___Family conflict ___Illness (child/parent)
___Job dissatisfaction ___Job layoff ___Job stress ___Job termination
___Lawsuit ___Marital discord ___Marital separation ___Marriage
___Parental Discord ___Personal Injury ___Pregnancy ___Abuse (physical, sexual, verbal)
___Retirement ___Unemployment ___Upcoming surgery ___Crime (witness/victim)

What areas of your life are being affected by the above?

Social
___Unable to form or maintain friendships
___Withdrawal from family and friends
(excessive desire to be alone)
___Increased conflict with others
___Loss of interest in social activities
___Phobias

Occupational
___Unable to maintain job
___Absenteeism
___Conflicts with co-workers
___Tardiness
___Reduced productivity
___Disciplinary action for poor performance

Affective Distress
___Crying spells
___Irritability
___Anger/rage
___Disorganized thoughts
___Feeling overwhelmed with emotions
___Emotional meltdowns/breakdowns
___Worrying that interferes with the ability to concentrate
___Memory problems
___Concentration problems

Physical
___Decreased energy/fatigue
___Difficulty getting out of bed or insomnia
___Decreased/Increased appetite
___Substantial weight loss or gain
___Physical complaints (headaches, stomachaches, etc.)
___Frequent illness

Family Information

Your current relationship status:
___Single ___Divorce in process ___Unmarried, living together ___Legally married
___Separated ___Divorced ___Widowed ___Annulment
___Engaged ___Other ____

If married, date of marriage: ________ # of times married: ______ # of times divorced: ______
Assessment of relationship with significant other (if applicable) ___Good ___Fair ___Poor ___N/A

Name	Age	Highest level of education	Occupation?	Living? (Yes or No)	Living with you? (Yes or No)
Mother: ____________________	___	_______	____________	_____	_____
Father: ____________________	___	_______	____________	_____	_____
Spouse: ____________________	___	_______	____________	_____	_____
Children: ____________________	___	_______	____________	_____	_____
____________________	___	_______	____________	_____	_____
____________________	___	_______	____________	_____	_____
____________________	___	_______	____________	_____	_____

**** Place a Star next to the children of whom you have custody.***

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives)
Please specify relationship:

Relationship	Name	Age	Living? Yes/No	Living w/you? Yes/No
__________________	______________________________	_____	______	_______
__________________	______________________________	_____	______	_______
__________________	______________________________	_____	______	_______
__________________	______________________________	_____	______	_______

Parental Information (Check those which apply)
____Parents legally married ____Parents separated ____Parents divorced
____Mother remarried # of times:____ ____Father remarried # of times: ____

Special circumstances (e.g., raised by person other than parent) ___________________________________

Case # ______________________

Counseling/Prior Treatment History (Information about client past and present)

	Yes	No	When	Where	Overall experience
Mental Health Counseling	___	___	__________	___________	_______________________
			__________	___________	_______________________
Suicidal thoughts/attempts	___	___	__________		
Drug/Alcohol treatment	___	___	__________	___________	_______________________
M.H. Hospitalizations	___	___	__________	___________	_______________________
Involvement w/self-help Groups (AA, al-alnon, etc.)	___	___	__________	___________	_______________________

Any immediate family in treatment currently? If yes, whom and where? _________________________

Previous mental health diagnosis(es): ____

Permission to contact Prior Mental Health professionals/hospitals? ___Yes ___No ___N/A

Development

Are there special, unusal, or traumatic circumstances that affected your development? ___Yes ___No

If Yes, please describe____

Has there been history of child abuse? ___Yes ___No If Yes, which? ___Sexual ___Physical ___Verbal

Other childhood issues ___Neglect ___Inadequate nutrition ___Poor health ___Other:________________

Comments regarding childhood development____

____

Social Relationships

Check how you generally get along with other people (check all that apply)

___Affectionate ___Aggressive ___Avoidant ____Fight/argue often ___Follower

___Friendly ___Leader ___Outgoing ____Shy/Withdrawn ___Submissive

___Other (specify)____

Do you have supportive friendships? ___Yes ___No

Sexual orientation___________________________Comments_______________________________________

Sexual dysfunctions? ___Yes ___No If Yes, describe: ____

Any history of being abused by others? ___Yes ___No If yes, what type(s) of abuse?

___Emotional ___Sexual ___Physical ___Verbal ___Other: ___________________________________

Any current behaviors or history as sexual perpetrator? ___Yes ___No

If yes, describe ____

Do you have a history of social problems (e.g. bullying, awkward social interactions)____________________________

____

Cultural/Ethnic

To which cultural or ethnic group do you belong? ____

Are you experiencing any problems due to cultural or ethnic issues? ___Yes ___No

If Yes, describe____

Other cultural/ethnic information____

Spiritual/Religious

How important to you are spiritual matters to you? ___Not at all ___Little ___Moderate ___Much

Are you affiliated with a spiritual or religious group? ___Yes ___No

If Yes, describe ____

Were you raised within a spiritual or religious group? ___Yes ___No

If Yes, describe ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No

If Yes, describe ____

Current Legal Status

Are you involved in any active cases (traffic, civil, criminal)? ___Yes ___No

If Yes, please describe and indicate the court and hearing/trial dates and changes________________________

Are you presently on probation or parole? ___Yes ___No

If Yes, please describe________________________

Are you: ☐ voluntarily attending therapy? ☐ Court ordered to therapy?

Past Legal History

Traffic violations ___Yes ___No DWI, DUI, etc. ___Yes ___No

Criminal involvement ___Yes ___No Civil involvement ___Yes ___No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education (Fill in all that apply)

Currently enrolled in school ___Yes ___No

___High school grad/GED Average school grades (current or previous)________________________

___Vocational Number of years ___ Graduated ___Yes ___No Major________________________

___College Number of years ___ Graduated ___Yes ___No Major________________________

___Graduate Number of years ___ Graduated ___Yes ___No Major________________________

Other training________________________

Special circumstances (e.g., learning disabilities, gifted) ________________________

Employment (Begin with most recent job, list job history)

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: __FT __PT __Temp __Laid-off __Disabled __Retired __Social Security __Student __Other

Military

Military experience? ___Yes ___No Combat experience? ___Yes ___No

Branch ________________________ Discharge date ________________________

Type of discharge ________________________ Rank at discharge ________________________

Relative family member in the service? ____Yes ____No Who?________________________

Leisure/Recreational/Interests/Social

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, social organizations, etc.)

Activity	How often now?	How often in the past?

Case # ____________________

Medical/Physical Health Condition (Check any problem areas you have or have had)
For each illness listed below, choose a single answer that best describes your health history.

Condition	Currently	In Past	Never	Condition	Currently	In past	Never
Abortion				Loss of consciousness			
Anemia				Memory loss			
Appetite change				Numbness			
Arthritis				Pain (daily, longer than 2 weeks)			
Asthma				Palpitations			
Back pain				Paralysis			
Blood in stool				Rheumatic fever			
Blurred vision				Seizures			
Caffeine use				Shortness of breath			
Chest pain				Skin disease			
Chicken pox				Sleep apnea			
Chronic cough				Sleep difficulties			
Colitis or irritable bowel				Stroke or TIA			
Confusion or disorientation				Swallowing difficulty			
Constipation				Dental problems			
Diabetes				Thyroid disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or indigestion			
Emphysema				Urination difficulty			
Fainting				Sexually transmitted disease			
Glaucoma				Weakness			
Head injury				Recent Weight gain			
Headaches (frequent)				Recent Weight loss			
Hearing loss				Malnutrition			
Heart disease				Epilepsy			
Miscarriage				HIV/AIDS			
Infertility				Hepatitis			
Low libido				Energy level change			
Multiple sclerosis				Other			

List any current health concerns: ____
List any recent health or physical changes:____

Case # ______________________

Please list all of your current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule	What dose do you take, and how often?	When was the most recent dosage change?	Prescribing Doctor

Please list all medication that you have taken in the past.

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?	Prescribing Doctor

Will you sign for permission to contact your prescribing doctor, if not your PCP? __ Yes __ No __N/A

Describe your overall compliance with the above medications ____
____

Please list all nutritional and herbal supplements that you currently take: ______________________________
____

Medication Allergies ____
Have you ever had any bad reactions (made you feel worse) to prior medications (if so, specify):
____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	____/week	______________________	______________________
Lunch	____/week	______________________	______________________
Dinner	____/week	______________________	______________________
Snacks	____/week	______________________	______________________

Additional comments on nutrition: ____
____

Do you feel suicidal at this time? ___Yes ___No Do you feel homicidal at this time? ___Yes ___No
If Yes, explain ____

Are you currently involved in any risk taking behaviors? ___Yes ___No
Please describe ____
____

Case # ______________________

List family history of mental illness/substance abuse:
Mother=MO Father=FA Sibling=S Grandmother=GM Grandfather=GF

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Suicide Attempt			
Death by suicide			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your ability to function at work or home?
If yes, please explain: ____
____

Chemical Use History – Have you <u>EVER</u> used any of the following?

Drug	Method of use/amount	Frequency of use	Age of first use	Age of last use
Alcohol				
"Meth"amphetamines				
Barbiturates				
Valium/Librium				
Cocaine/Crack				
Heroin/Opiates				
Marijuana				
PCP/LSD/Mescaline				
Inhalants				
Xanax, Klonopin, Ativan				
Caffeine				
Nicotine				
Over-the-Counter				
Prescription drugs				
Other				

Substance(s) of preference
1. _________________________________ 2. _______________________________

3. _________________________________ 4. _______________________________

Describe when and where you typically use substances: ____________________________________

____

Case # ____________________

Describe any changes in your use pattern: ____
____

Describe how your use has affected your family or friends (include their perceptions of your use):
____

Reason(s) for use:
___Addicted ___Build confidence ___Escape ___Self-medication
___Socialization ___Taste ___Other:____

How do you believe your substance use affects your life? ______________________________
Who or what has helped you in stopping or limiting your use? ___________________________

___Has your use of alcohol or drugs interfered with your obligations at work?
___Has your use of alcohol or drugs interfered with your obligations at school?
___Has your use of alcohol or drugs interfered with your obligations at home?

___Have you used alcohol or drugs while driving a vehicle or operating machinery?
___Have you ever been arrested as a result of drinking or using drugs?
___Have you continued to use alcohol/drugs despite having problems caused by the effects of alcohol/drugs?

___Have you ever used more alcohol/drugs in order to achieve the desired effect?
___Has there become a markedly diminished effect with the continued use of the same amount of the substance?
___Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?

___Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
___Have you attempted to cut down or control the amount of drinking or drug use without success?
___Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?

___Have you given up or reduced important social, occupational, or recreational activities because of your use of alcohol or drugs?
___Have you continued to use alcohol or drugs despite knowing physical, psychological, or legal problems are likely to occur?

Is there anything further that you would like to add in regard to your overall history?
____
____

Goals for Therapy

Please list your goals for therapy. In other words, what do you want to see changed by coming to therapy?
____
____

By signing below I am indicating that the above information is accurate to the best of my ability.

_______________________________________ _________________________
Client Signature Date

For Office Use Only:

_______________________________________ _________________________
Therapist's Signature/Credentials Date

Revised 06/25/2011

Case # ____________________