3269 US HWY 231 Suite #127, Ozark, AL 36360
(334) 625-0323

Adult Intake Form

DEMOGRAPHIC INFORMATION

Date: _____

Name:

_____

Last First Middle Maiden

Last 4 digits of Social Security #:_____ Birthdate: _____/_____/_____ Sex: _____ Age: _____

Race: White, Caucasian / Black, African American /Asian / Hispanic / Puerto Rican / Cuban / Mexican / American Indian / Native Hawaiian, Pacific Islander / Alaskan Native / other_____

Mailing Address:_____
Street Address

_____

City State Zip Code Home Phone Cell Phone

FINANCIAL

Insurance Provider:_____ Policy#:_____ Group#_____

Policy Holder's Name:_____ Policy Holder's DOB:_____

EMERGENCY CONTACT

Who typically lives with you? Spouse / significant other / children / parents / other family / friends / no one / other_____

Emergency Contact:_____
Name Relationship Telephone

Who referred you? _____
Name Organization Telephone

What are your goals for counseling? _____

Client Signature:_____ **Date:**_____

MEDICAL HISTORY

Do you have any medical problems? Yes / No If so, explain: _____

_____

Are you allergic to anything? Yes / No If so, list: _____

Are you on, or supposed to be on, any medication(s)? Yes / No If so, list: _____

Are you pregnant? Yes / No / NA How many months? _____ Complications?_____ Last Appt?_____
How has this problem affected your medical/physical health? _____

EMPLOYMENT

Are you employed: full-time / part-time / unemployed / retired / home maker

Current employer: _____ Previous Employer_____

Have your co-workers noticed this problem? Yes / No / NA How many jobs have you lost *or* left because of this problem? _____

Has this problem affected your work/employment? If yes, explain: _____

VOCATIONAL

Last grade completed in school: _____

Any College/Voc. Rehab.? Yes / No Major/Degree:
_____

Has this problem affected your school performance? If yes, explain: _____

_____

MENTAL/EMOTIONAL HEALTH

Have you ever been treated by a mental health professional? Yes / No If so, explain: _____

_____

Have you ever been in the hospital for mental or emotional reasons? Yes / No If so, explain: _____

_____

Have you ever tried to kill yourself or anyone else? Yes / No If so, explain: _____

_____

Recently, have you had any thoughts of wanting to kill yourself or anyone else? Yes / No If so, explain: _____

_____

If suicidal or homicidal, how likely are you to go through with it? very likely / likely / depends / not likely / definitely won't / NA

How has this problem affected you mentally/emotionally? _____

SEXUALITY

Are you *or* have you ever had any confusion about your sexuality or gender? Yes / No If so, describe: _____

_____

Do you have *or* fear you have any sexually transmitted diseases (STD'S)? Yes / No If so, explain: _____

_____

How has this problem affected your sex life? _____

_____

RELIGION

How do you feel about religion and/or spirituality? _____

What religion, if any, are you a part of now? _____

How has this problem affected your religious/spiritual life? _____

_____

FAMILY

Marital status: single / married / separated / divorced / widowed / common law

For how long? _____

How many times have you been married? _____

Why did your other marriages fail? _____

_____

Has your significant other noticed this problem? Yes / No / NA Explain: _____

_____

How has this problem affected your relationship with your significant other? _____

_____

Has anyone else in your family noticed this problem? Yes / No / NA Explain:_____

_____

How has this problem affected other family relationships?_____

_____

How has this problem affected your relationship with your children? _____

Number of children? _____biological _____step Ages? _____biological _____step

Number of siblings? _____biological _____step Ages? _____biological _____step

Who raised you? mother / father / other family / foster care / adoptive parents / other: _____

List people that were close to you that have died and when: _____

_____

Do you have a family history of mental illness? Yes / No / Unsure If so, explain: _____

_____

Do you have a family history of substance abuse? Yes / No / Unsure If so, explain: _____

_____

Have you ever been physically, mentally, emotionally, and/or sexually abused? Yes / No If so, describe: _____

_____

What is the biggest problem from childhood that you can remember having? _____

_____

What was your parent's relationship like: _____

LEGAL

Do you have any *current* legal problems? Yes / No If so, explain: _____

_____

Do you have any upcoming court dates? Yes / No If so, when? _____

Write in the blank how many times you have been arrested for each of the following:

DUI_____, disorderly conduct_____, forgery_____, robbery_____, burglary_____, murder_____, rape_____,

public intoxication_____, assault_____, battery_____, theft_____, possession_____, distribution_____, trafficking_____,

prostitution_____, domestic violence_____, other_____

What do professional(s) need to know about your assessment today?

_____

Do you have a valid driver's license? Yes / No

MILITARY

Have you ever been in the military? Yes / No What branch of service? _____

Highest Rank obtained: _____ Combat experience: yes / no / NA

Date of discharge: _____ Type of discharge: _____

Do you have any emotional, substance abuse, or medical problems related to your military experience: Yes / No / NA If so,

explain: _____

SUBSTANCE ABUSE

Has there ever been a time in your life when you or someone else felt as though you drank or used drugs too much or too often? Yes / No

If so, explain: _____

_____

_____

Have you ever had substance abuse treatment before? Yes / No If so, describe: _____

_____

When was the last time you drank or used illegal drugs? _____

How often do you engage in this activity? _____

What and how much do you typically consume? _____

_____