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Adult Client Intake Form

Name: _____ Date: _____

Birthdate: _____ Age: _____ Gender: ___ M ___ F

Address

Phone: _____ (___ H, ___ W, ___ C) Ok to leave message? ___ Y ___ N
_____ (___ H, ___ W, ___ C) Ok to leave message? ___ Y ___ N

Email _____ Ok to E-Mail? ___ Y ___ N
** Please be aware that we cannot guarantee the confidentiality of e-mail communication

Marital Status: ___ Single/Never Married ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed

Children: Total Number: _____ (___ Girls, ___ Boys)

How did you hear about/find us? _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Have you ever had counseling/psychotherapy in the past? ___ Y ___ N
** If yes, please list the organization/name of your counselor below

Are you currently receiving psychotherapy/counseling services elsewhere? ___ Y ___ N
** If Yes, please list the organization/name of your counselor below

Please describe the events/circumstances that are bringing you to seek counseling/therapy at this time

Please Identify any of the following symptoms you are currently experiencing

Physical

- | | | |
|--|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Racing Heart | <input type="checkbox"/> Motor Ticks |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Aches and Pains | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Upset Stomach/Nausea | <input type="checkbox"/> Unable to Relax |
| <input type="checkbox"/> Trembling/Shaking/Tremors | <input type="checkbox"/> Changes to Sleep Patterns | <input type="checkbox"/> Frequent Tension in the Body |
| <input type="checkbox"/> Changes in Appetite/Eating Patterns | <input type="checkbox"/> Changes in Sex Drive/Sexual Activity | |

Mental

- | | | |
|---|---|---|
| <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Obsessions (thoughts, etc.) | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Homicidal Thoughts | <input type="checkbox"/> Recurring, Distressing Dreams | <input type="checkbox"/> Distressing Dreams |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Hallucinations (Auditory, Visual, Etc) | |
| <input type="checkbox"/> Nightmares about Traumatic Experience(s) | | |
| <input type="checkbox"/> Frequent Worry Phobias/Unusual Fears about Specific Things | | |
| <input type="checkbox"/> Recurring, Distressing Thoughts about Trauma "Flashbacks" as if reliving Traumatic Experience(s) | | |
| <input type="checkbox"/> Delusions (Detachment from Reality - Paranoid, Grandiosity, Etc.) | | |

Emotional

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Feeling Anxious or "on Edge" | <input type="checkbox"/> Feeling Stressed | <input type="checkbox"/> Feeling Overwhelmed | <input type="checkbox"/> Feeling Panicky |
| <input type="checkbox"/> Feeling Irritable/Angry | <input type="checkbox"/> Feeling Shy | <input type="checkbox"/> Feeling "Down" or "Sad" | <input type="checkbox"/> Feeling Guilty |

Behavioral

- | | | | | |
|---|---|--|------------------------------------|----------------------------------|
| <input type="checkbox"/> Suicide Attempt(s) | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Crying | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Anger Outbursts | <input type="checkbox"/> Running Away | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Isolation | <input type="checkbox"/> Blaming |
| <input type="checkbox"/> Using/Manipulating | <input type="checkbox"/> Self Harm/Mutilation | | | |

Have you been prescribed and/or taken any psychiatric medication(s) in the past? ___ Y ___ N

** If yes, please list medication(s) below

Are you currently prescribed and/or taking any psychiatric medication(s)? Y N

** If yes, please list medication(s) below

Please list any other medication(s) you are taking

Have you experienced significant weight change in the last 2 months? No Yes

Do you regularly use alcohol? No Yes

How often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

Have you had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Have you had them in the past?

Frequently Sometimes Rarely Never

Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

Is there a history and/or current experience of domestic violence in this relationship? Y N

** This includes physical altercations, verbal put-downs, threats, coercion, etc.

In the last year, have you experienced any significant life changes or stressors:

Personal Mental Health History

Have you ever experienced any of the following?

Extreme depressed mood: No Yes

Extreme Mood Swings: No Yes

Rapid Speech: No Yes

Extreme Anxiety: No Yes

Panic Attacks: No Yes

Phobias: No Yes

Sleep Disturbances: No Yes

Hallucinations: No Yes

Unexplained losses of time: No Yes

Unexplained memory lapses: No Yes

Alcohol/Substance Abuse: No Yes

Frequent Body Complaints: No Yes

Eating Disorder: No Yes

Body Image Problems: No Yes

Homicidal Thoughts: No Yes

Suicide Attempt: No Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): No Yes

Repetitive Thoughts (e.g., Obsessions): No Yes

Domestic Violence: No Yes

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Depression: ____ No ____ Yes - _____

Bipolar Disorder: ____ No ____ Yes - _____

Anxiety Disorders: ____ No ____ Yes - _____

Panic Attacks: ____ No ____ Yes - _____

Schizophrenia: ____ No ____ Yes - _____

Alcohol/ Substance Abuse: ____ No ____ Yes - _____

Eating Disorders: ____ No ____ Yes - _____

Learning Disabilities: ____ No ____ Yes - _____

Trauma History: ____ No ____ Yes - _____

Suicide Attempts: ____ No ____ Yes - _____

Domestic Violence: ____ No ____ Yes - _____

Occupational History

Are you currently employed? No Yes

If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

Religious/Spiritual Information (*Leave this question blank if you would rather not answer)

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

Other Information

What do you consider to be your strengths?

What are some refractive ways of coping that you have learned?

What are some goals you have for counseling?
