Adult Intake Form

CLIENT INFORMATION

Client name_______________________________________ Male________ Female_______

Address____ Date of Birth_____________Age__________

City & Zip Code __________________________________ Ethnicity__________Marital Status _______

Phone (Home)_____________________ (Cell)______________________ (Work)____________________

What number may we leave a confidential message? (circle) Home Work Cell Text

Email address:_____________________________________May we send an appointment reminder? Y/N

How did you hear about New Solutions Counseling? ______________________________

EMERGENCY CONTACT

Name_____________________________________ Relationship______________________________

Phone______________________________ Alternate phone _____________________

May we contact in case of an emergency? Y/N

EMPLOYMENT/EDUCATION

Current Employer_______________________________Occupation________________________________

School attending_____________________ College_____________________ Year_________

Highest level of education completed___________________Degree received ______________________

MEDICAL HISTORY

Primary Care Physician________________________________ Location_______________________

Please list health problems including allergies

____

____

Please list any hospitalizations (include dates/reasons)

____

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MEDICAL HISTORY (continued)

Please list all medications you are current taking and the dosage/frequency of use below

MEDICATION	DOSAGE/FREQUENCY

Have you ever been treated for substance abuse? Yes No

Provider and dates of treatment ____

Please check how often you do the following:

Smoke? _Never _______ Monthly ______ Weekly Daily Drink Amount_______________
Alcohol? _____ Never _____ Monthly ___ Weekly Daily _ Use Drugs? Amount_______________
Never Monthly _ Weekly Daily______ Amount _______________

REASON FOR SEEKING COUNSELING

Please state the reason you are seeking professional counseling services at this time.

Please list your goals for counseling

1) ____

2) ____

3) ____

4) ____

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SYMPTOM CHECKLIST

Please identify symptoms that relate to the reason you are seeking counseling at this time: (circle any areas of concern)

How would you rate the seriousness of your present situation in severity 1-10

Now ___________ 6 Months ago __________ Year ago ________

Anxiety
Anger/Irritability
Domestic Violence
Neglect Guilt/Feelings of Worthlessness
or Family) Poor Concentration
Mood Changes
Sexual Problems
Sexual Assault/Rape
Depression
Other _____________________

Thoughts of Suicide/Death
Thoughts of Homicide
Childhood Abuse or
Alcohol or Drug use (Self
Grief/Loss
Chronic Pain
Sleeping Problems
Gender Identity Issues
Self-esteem
Relationship conflicts

HAVE YOU EVER EXPERIENCED ANYTHING YOU PERCEIVED AS TRAUMATIC?

____
____
____
____
____
____
____

(Examples: robbery, rape, death in family, domestic violence, sexual abuse, emotional abuse, physical abuse, severe injury, combat. ***(trauma can be either witnessed or experienced).***

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PSYCHIATRIC HISTORY

Have you ever been abused sexually, verbally, emotionally or physically? YES NO

Please explain ____
____
____

Are you currently or have you in the past had thoughts of suicide or self-harm (cutting, burning, etc.)? YES NO If current please indicate YES NO

Please explain ____

PRIOR MENTAL HEALTH COUNSELING

Provider/therapist	**Period of treatment (date/year)**

Previous Diagnosis ____
____

Does your biological mother have a history of mental or emotional problems or substance abuse? If yes, please explain. ____
____

Does your biological father have a history of mental or emotional problems or substance abuse? If yes, please explain. ____
____

Is your Mother living______or deceased____? Father_______living or deceased______?

Has anyone in your family ever attempted suicide? YES NO Committed suicide? YES NO

Relationship to you _______________________

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PERSONAL/ SOCIAL HISTORY

Briefly describe your childhood.

____
____
____
____
____
____
____

(Examples: happy, unhappy, no contact with parent, single parent home, blended family, divorce, alcohol abuse, adopted, sexual, physical, verbal abuse, legal problems, strong religious beliefs).

Briefly describe your father (or father figure) and your relationship with him:

Briefly describe your mother (or mother figure) and your relationship with her:

Siblings:

Name	Age	Describe your relationship with sibling
______________________	_______	________________________________
______________________	_______	________________________________
______________________	_______	________________________________
______________________	_______	________________________________
______________________	_______	________________________________
______________________	_______	________________________________

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Did you have any developmental or learning challenges when you were young? (trouble in school, late reaching milestones, special education services, etc.)? Please describe.

____

____

____

2. Have you ever been arrested, or been involved in a legal situation? Please describe.

____

____

____

3. Please note if you have particular religious, cultural, or spiritual beliefs that you would like the therapist to be aware of. Would you like your spiritual beliefs incorporated into the therapeutic process?

____

____

4. Please list hobbies or extracurricular interests you have.

____

____

5. What do you consider to be your strengths?

____

____

____

6. What do you consider areas you would like to improve upon?

____

____

____

7. Who in your life provides you support when experiencing stress? (friends, family, etc.)

____

8. Please list all marriages and children/stepchildren from each marriage.

Marriage (year)	Years married	Child(ren) names	Age(s)
________________	________	__________________________	_____________
________________	________	__________________________	_____________
________________	________	__________________________	_____________

9. List any additional information that would be helpful for me to better understand you and/or your concerns.

____
____
____