Adult Intake Form

Personal Information

Date: _____

Last Name: _____ First Name: _____ M.I.: _____
Age: _____ Date of Birth: _____ Gender: _____ Social Security #: _____
Street Address:

_____

City: _____ State: _____ Zip code: _____
Ok to send mail: _____ If no, please provide alternate address: _____

_____

Home phone: _____ Ok to leave a message: _____
Cell phone: _____ Ok to leave a message: _____
Work phone: _____ Ok to leave a message: _____

Name of emergency contact: _____ Relationship to you: _____
Address: _____
Home Phone: _____ Cell/Work Phone: _____

Referral Source (how you heard about counseling services): _____

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Health Information

Please answer the following questions using: 5 – Excellent, 4 – Good, 3 – Average, 2 – Poor, 1 - Failing

How would you currently rate your physical health: _____
How would you currently rate your mental health: _____
How would you currently rate your spiritual health: _____ (if does not apply to you, please use N/A)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

_____
_____
_____
_____
_____

Medical Information

Do you now have, or have you had in the past, any of the following? Check all that apply:

Asthma			Allergies			Headaches		
Brain Injury			Epilepsy			Seizures		
Digestive Disorders			Cancer			Diabetes		
Breathing Problems			Immune System Problems			Heart Disease		
High Blood Pressure			Vision Problems			Hearing Problems		
Arthritis			Urinary Disorders			Tuberculosis		
Thyroid Disorder			Multiple Sclerosis			Chronic Fatigue Syndrome		
Fibromyalgia			Pregnancy (how many)			Miscarriage (how many)		
Abortion (how many)			Sexually Transmitted Disease			Sleep Disorder		
Serious Accident			Surgery			Other		

Are you currently under the care of a Doctor or other medical health professional: _____

Name of Primary Care Physician: _____ Physician Phone #: _____
Address: _____

Name of Specialist Physician: _____ Physician Phone#: _____
Address: _____

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Please list any prescription medications you are currently taking: _____

_____

_____

_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____

_____

_____

Do you currently exercise: _____ If yes, please indicate how many times per week: _____

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have you ever believed your substance use was a problem for you: _____
Has anyone ever told you they believed your substance use was a problem: _____
Have you ever had withdrawal symptoms when trying to stop using any substances: _____
Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

_____

Have you ever participated in drug and alcohol treatment: _____ If yes, please list type, length, dates, and age at time you received these services: _____

_____

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous: _____ If yes, please list length of time sober and number of meetings you attend per week: _____

_____

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Mental Health Information

Have you ever been in counseling/therapy before: _____ If yes did you find it helpful or effective: _____

_____

_____

Are you currently receiving mental health services: _____ If yes, please list name of practitioner and type of services you are receiving: _____

Have you ever been hospitalized for mental health concerns: _____ If yes, list date(s) and length of stay:

_____

_____

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date (s) first diagnosed: _____

_____

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and illness(es): _____

_____

Have you ever or are you currently engaging in self harm? Currently: _____ Past: _____
Have you ever or are you currently contemplating suicide? Currently: _____ Past: _____
Have you ever or are you currently contemplating harming another person? Currently: _____ Past: _____

Have you ever attempted suicide: _____ If yes please list date(s), method(s), and your age at time of attempt: _____

_____

Has any one in your family ever attempted suicide: _____ If yes please list relationship: _____
Has any one in your family ever completed suicide: _____ If yes please list relationship: _____
Has any one else in your life ever attempted _____ or completed suicide: _____ Relationship: _____

Do you currently or have you ever had trouble sleeping: _____ If yes, please describe: _____

_____

_____

Do you currently or have you ever had problems with eating or with food: _____ If yes, please describe:

_____

_____

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:

_____

_____

_____

_____

_____

_____

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Spiritual Information

Have you ever or do you currently engage in a personal faith practice: _____ If yes please describe:

_____

_____

_____

Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.: _____ If yes, please describe your current level of connection and involvement:

_____

_____

_____

Do you want to incorporate your faith/spirituality into the counseling process: _____ If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction:

_____

_____

_____

Relationship Information

Are you currently in a relationship: _____ If yes, please list status: _____
Name of Person: _____ Length of time you have known each other: _____
Length of time you have been together: _____ Do you currently live together: _____

Number of marriages: _____ Number of divorces: _____ If widowed, your age at death of spouse: ____

Do you have children: _____ If yes, please list below:

Name	Age	Lives with you	Name	Age	Lives with you

If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties you would like to address in individual counseling, please briefly describe: _____

_____

_____

_____

_____

Other persons living in your household and your relationship to them: _____

_____

_____

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Family Information

Were you adopted: _____ If yes, your age at time of adoption: _____

With whom did you live until the age of 18: _____

_____

Did your parents ever divorce: _____ If yes, your age at time of divorce: _____

I divorced, did your parents ever re-marry: _____ If yes, list parent(s) and your age(s) at time of remarriage: _____

_____

Were you ever in foster care or residential care: _____ If yes, please list age and living situation:

_____

_____

Mother's current age: _____ If deceased, her age at death: _____ Your age at time of her death: _____
Father's current age: _____ If deceased, his age at death: _____ Your age at time of his death: _____

Do you have siblings: _____ If yes, please list names, ages, and relationship:

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever experienced the death of a family member or a close friend: _____ If yes please list relationship and your age at time of their death: _____

_____

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Frequent/Multiple Moves			
Sexual Abuse				Homelessness			
Domestic Violence				Financial Problems			
Neglect				Lived over-seas			
Substance Abuse				Military member			
Serious Illness				Discrimination			
Accident or Injury				Other			

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Educational Information

Number of years of education completed: _____ Degree(s) achieved (please mark all that apply):

High School Diploma		G.E.D.		Vocational/Trade School Certificate		Associates Degree	
Bachelors Degree		Masters Degree		Doctorate Degree		Other	

Vocational Information

Are you currently employed: _____ If yes, please list position title, name of employer, type of work, and length of time at employment: _____

_____

If you are not currently working, how long have you been un-employed: _____
What types of jobs have you typically held: _____
What is the longest period of time you have ever worked at one job: _____
Are you currently considering a change in job or career: _____ If yes, what type of work are you interested in doing: _____

_____

Have you ever served in the military: _____ If yes, please list branch, rank, and current status (active/discharged): _____
If deployed please list dates and family/relationship status pre and post deployment: _____

_____

_____

_____

Please list your personal hobbies and interests: _____

_____

_____

_____

Legal Information

Have you ever been the victim of a crime:_____ If yes, please list date and briefly describe: _____

_____

_____

Are you currently involved in divorce or child custody proceedings: _____ If yes, please explain: _____

_____

_____

Have you ever been convicted of a misdemeanor or felony: _____ If yes, please explain: _____

_____

_____