adult intake form

Please print out this form, complete it, and bring it to the first session. Leave blank any question you would rather not answer. Information you provide here has the same standards of confidentiality as therapy.

Client Information

Last Name: ______________________ First Name:____________________ Middle Initial:___________

Address: ______________________________________City:___________________________________

State:____________ Zip:_________ Phone (Day#): ___________________ (Cell #):_________________

Email: _____________________________

May I leave a message on your telephone? __Yes __No If yes, on which number(s)?_______________

May I mail counseling information to your home? __Yes __No

What is the highest level of education achieved? ______________

Current occupation?_____________________________________ For how long? _____________

Previous occupations ____

Relationship Information

To whom do you turn for support? (i.e. family/friends/other) ___________________________________

____

What is your current marital status? __ Single __ Married __ Separated __ Divorced __ Widowed

If married, spouse's name _____________________ How many marriages have you had? ___________

Have you ever been divorced? __Yes __No If yes, when? ___________________________

Have you ever been separated? __Yes __No If yes, when? ___________________________

Children:

Name _________________________________ M F Age _____________

Name _________________________________ M F Age _____________

Name _________________________________ M F Age _____________

If you are separated or divorced:

Do you have at least partial custody of your child(ren)? __Yes __No

If yes, what percentage of the time does your child(ren) reside with you? ___________________

With whom does your child(ren) reside when they are not with you?_______________________

Personal Spiritual Information

Do you believe in God? __Yes __No   Are you a Christian? __Yes __No

If not, how would you describe your religious beliefs? ____

Please describe the significance of faith in your life? ____

____

____

How much influence does your religion/ faith have on your day-to-day activity?

__ A lot   __ A moderate amount   __ A little   __ None

If you are married, do you and your spouse agree on religious issues? __Yes __No

If no, describe your differences:____

____

Are you an active member of a church? __ Yes __ No   If yes, which one? _________________________

Mental Health History

Have you previously been treated by, consulted with, or received counseling/therapy from a mental health professional? __Yes __No   If yes, when? ______________

Are you currently under the care of a mental health professional? __Yes __No

If yes, what is that professional's name?______________________________________

Have you ever been diagnosed with or treated for any type of mental illness? __Yes __No

If yes, what was the diagnosis? ____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?

__Yes __No   If yes, what was the diagnosis? ____

Counseling Information - Reasons for Seeking Help

What concerns bring you to seek counseling services? ____

____

____

When did the present concerns begin to be a problem for you? ____________________________________

____

____

What do you hope to gain from counseling? ____

____

____

What do you consider to be your strengths? ____

____

____

What do you like most about yourself? ____

____

____

What are some of your coping skills? ____

____

____

What are some of your extracurricular activities and interests? ____________________________________

____

____

What other information would you like to share about yourself? ___________________________________

____

____

Physical Health Information

How is your physical health at present? __ Poor __ Unsatisfactory __ Satisfactory __Good __Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes etc.) ____

Are you having any problems with your sleep habits? __No __Yes

If yes, check where applicable:

__Sleeping too little __Sleeping too much __Poor quality sleep

__Disturbing dreams __Other _________________

How many times per week do you exercise? _____ Approximately for how long at a time? __________

Are you having any difficulty with appetite or eating habits? __No __Yes

Do you regularly use alcohol? __No __Yes If Yes, how often? ____________________

Do you engage in recreational drug use? __No __Yes If Yes, how often? ____________________

Please indicate which of the following problems you experience. Check all that apply:

Headaches	Feeling helpless	Hopelessness	Dizziness
Stomach problems	Crying a lot	Low energy	Sleep issues
Memory problems	Worrying a lot	Irritable mood	Confusion
Racing thoughts	Fears	Phobias	Paranoia
Euphoria	Suicidal thoughts	Panic attacks	Mood swings
Excessive energy	Gambling problems	Homicidal thoughts	Unusual thoughts
Weird feelings	Financial problems	Legal problems	Suspicion
Depression	Recurring unwanted thoughts	Poor concentration	Bingeing
Weight loss	Anger problems	Can't enjoy life	Weight gain
Worthlessness		Impulsive behavior	