Purposeful Counseling
Lindsay Jaques, LPC, LMHC
305 W 16th Street
Vancouver, WA 98660
503.319.0678

ADULT COUNSELING INTAKE FORM

Client Information:

Client Name(s): _____Date: _____

Gender: ☐Male ☐Female Age: _____ Date of Birth: _____

Ethnic Background: _____

Spiritual Practice/ Religious Affiliation: _____

Do you have an interest in spiritual growth: ☐ Yes ☐ No

Currently attending church/ temple/ mass/ etc.: ☐ Yes ☐ No

Educational Background: _____

Occupation: _____

Referral Source: _____

Clinical Information:

Reason for Coming to Counseling. _____

Major Sources of Stress: _____

POSSIBLE CONCERNS FOR DISCUSSION IN COUNSELING:

☐ Abuse (physical, sexual, emotional) _____Past or present (circle one)

☐ Alcohol use	☐ Finances	☐ Self-control
☐ Anger	☐ Friends	☐ Self-esteem
☐ Appetite	☐ Gambling	☐ Shyness
☐ Career	☐ Health problems	☐ Sleeplessness
☐ Children	☐ Inferiority feelings	☐ Stress
☐ Concentration	☐ Legal matters	☐ Suicidal thoughts
☐ Depression	☐ Loneliness	☐ Thoughts
☐ Dreams	☐ Making decisions	☐ Tiredness
☐ Drug use	☐ Marriage	☐ Unhappiness
☐ Education	☐ Memory	☐ Work
☐ Energy	☐ Nervousness	☐ Other
☐ Fears	☐ Relaxation	

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Relationship: Please check those of concern.

☐ Affection	☐ Holding other down	☐ Showing appreciation
☐ Agreeing on chores	☐ Housing	☐ Solving problems together
☐ Closeness	☐ Infidelity	☐ Spouses/ partner cleanliness
☐ Common goals	☐ In-laws	☐ Trusting each other
☐ Common interests	☐ Jealousy	☐ Use of time
☐ Communication	☐ Parenting	☐ Verbal fighting
☐ Feeling Misunderstood	☐ Physical fighting	☐ Other:_____
☐ Finances	☐ Recreation	_____
☐ Friendships	☐ Relatives	_____
☐ Having fun together	☐ Sexual Issues	_____

Please note any other individual or relationship concerns you might have:

_____
_____
_____

Ways of Coping:

_____
_____

What do you consider to be your most significant strengths:

_____

Previous Counseling:

Type of treatment (inpatient/ outpatient)	Provider	Approximate date range of treatment	Reason for treatment	Beneficial?

Habits/ Substance Use (Please add any illicit drugs or abuse of prescription medications as is applicable)

Substance	**Amount**	**Frequency**	**Last use**
Caffeine			
Alcohol			
Cigarettes/Nicotine			

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Have you ever abused drugs or alcohol? ☐**Yes** ☐**No**

Substance Use Treatment:

Type of treatment (outpatient/ residential/ detox)	Provider/ Facility	Approximate date range of treatment	Reason for treatment (specify drug or alcohol abused)	Beneficial?

Family Information:

Marital Status: ☐Married ☐ Divorced ☐Separated ☐Single ☐Widowed

Length of current relationship: _____

Spouse/ Partner's Name: _____ Date of Birth: _____

Previous Marriages/ Significant partners and length of relationships:

_____

_____

Children (Include all biological, adopted, foster, and step):

Name	Sex	Age	Type (B,A,F, S)	Custody Y/N	Lives with
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

Coping and Supports:

Are you currently engaged in hobbies/activities? ☐**Yes** ☐**No**

If so, please identify: _____

Do you exercise? ☐**Yes** ☐**No**

If so, please describe how often and what you enjoy doing for exercise:

_____

Who do you consider to be your support system?

_____

_____

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Family History:

Father's name: _____

Please use 5 words to describe your father:

_____

Mother's name: _____

Please use 5 words to describe your mother:

_____

Step-parent's names (and brief description of each):

_____

_____

Do you have any brothers and sisters (including step, foster, and adopted)? _____

Name	Sex	Age	Type (B,A,F, S)	Lived with you? Y/N	Describe relationship
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

How would you describe your childhood?

_____

_____

Any family history of mental illness, Serious Medical Illness, or Substance abuse issues:

_____

_____

_____

Medical History:

Are you presently under a physician's care? ☐ Yes ☐ No

Name and phone number of physician: _____

If yes, What for?

_____

_____

Prescription medications, vitamins, sleep aids, other supplements currently taking (include name, dosage, and frequency)_____

_____

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Treatment Goals:

If counseling were successful, what would be noticeably different?

_____
_____
_____

Do you have any questions for me?

_____
_____

Are there any hesitations, fears, or concerns about counseling?

_____
_____
_____

Please list your main counseling goals:

_____

_____

_____

_____

_____

Other: _____

_____