Adult Intake Form

Please provide the following information and the questions below.
Please note: information you provide here is protected as confidential information.

PERSONAL HISTORY

Client name: _____

Preferred name: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Religious Affiliation (if any):_____

Present Marital Status: _____

If married, years married to spouse: _____

Home Phone: _____ May I leave a message? Yes☐ No☐

Cell/Other Phone: _____ May I leave a message? Yes ☐ No ☐

Email: _____ May I email you? Yes☐ No☐

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

COUNSELING HISTORY

Have you ever received counseling in the past? Yes☐ No☐

If Yes, please briefly describe: _____

_____

_____

_____

Are you currently seeing a psychiatrist? Yes☐ No ☐

If Yes, name of psychiatrist_____

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Have you ever been hospitalized for a psychiatrist condition? Yes☐ No ☐

If Yes, describe: _____

_____

_____

What is (are) your main reason(s) for this visit? _____

_____

_____

How long has this problem persisted? _____

Under what circumstances do your problems usually get worse? _____

_____

_____

_____

Under what conditions are your problems improved? _____

_____

_____

_____

MEDICAL HISTORY:

Physician's Name: _____

Address/Phone: _____

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Intake

Current Medications (if you need more room, please write on the back of this page):

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Medication	Purpose

On average how many hours of sleep do you get daily? _____

Do you have trouble falling asleep at night? Yes ☐ No ☐

Have you gained/lost over ten pounds in the past year? Yes ☐ No ☐
Gained ☐ Lost ☐
If Yes, was the gain/loss on purpose? Yes ☐ No ☐

Describe your appetite (during the past week):

Poor appetite ☐ Average appetite ☐ Large Appetite ☐

Do you smoke or use tobacco? YES ☐ NO ☐
Do you consume caffeine? YES ☐ NO ☐
Do you drink alcohol? YES ☐ NO ☐
Do you use any non-prescription drugs? YES ☐ NO ☐
If YES, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? Y ☐ N ☐
Have you ever been in trouble or in risky situations because of your substance use? Y ☐ N ☐

If YES, how much per day?_____ If YES, how much per day?
_____ If YES, how much per day/week/month/year? ____

FAMILY HISTORY:

Mother's age_____ Father's age_____

Are your parents still married? _____ If they divorced, widowed or deceased, how old

were you when they separated, divorced and or died, and how did this impact you?

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_____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life:

_____

Number of sisters? _____ Their ages? _____

Number of brothers? _____ Their ages? _____

I was child number _____ in a family of _____ children.

Were you raised with parents other than your natural parents? Yes☐ No☐

Briefly describe your relationship with your bothers and/or sisters:

_____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Number of Children?☐ Names and ages:☐

_____

_____

_____

List the names and ages of those living in your household: _____

_____

History of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: Poor ○1○2○3○4 ○5○6 ○7 Excellent

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Please briefly describe your coping mechanisms and self-care:_____
_____
_____

Is spirituality important in your life and if so please explain:_____
_____
_____

Briefly describe your diet and exercise patterns:_____
_____
_____

EDUCATION & CAREER

Years of Education: _____

What is your current employment?_____

Employment Satisfaction: Poor ○1 ○2 ○3 ○4 ○5 ○6 ○7 Excellent

What do you think are your strengths?_____
_____
_____
_____

What do you think are your weaknesses? _____

_____
_____
_____

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

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DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety	☐	☐	People in General	☐	☐	Nausea	☐	☐
Depression	☐	☐	Parents	☐	☐	Abdominal Distress	☐	☐
Mood Changes	☐	☐	Children	☐	☐	Fainting	☐	☐
Anger or Temper	☐	☐	Marriage/Partnership	☐	☐	Dizziness	☐	☐
Panic	☐	☐	Friend(s)	☐	☐	Diarrhea	☐	☐
Fears	☐	☐	Co-Worker(s)	☐	☐	Shortness of Breath	☐	☐
Irritability	☐	☐	Employer	☐	☐	Chest Pain	☐	☐
Concentration	☐	☐	Finances	☐	☐	Lump in the Throat	☐	☐
Headaches	☐	☐	Legal Problems	☐	☐	Sweating	☐	☐
Loss of Memory	☐	☐	Sexual Concerns	☐	☐	Heart Palpitations	☐	☐
Excessive Worry	☐	☐	History of Child Abuse	☐	☐	Muscle Tension	☐	☐
Feeling Manic	☐	☐	History of Sexual Abuse	☐	☐	Pain in joints	☐	☐
Trusting Others	☐	☐	Domestic Violence	☐	☐	Allergies	☐	☐
Communicating with Others	☐	☐	Thoughts of Hurting Someone Else	☐	☐	Often Make Careless Mistakes	☐	☐
Drugs	☐	☐	Hurting Self	☐	☐	Fidget Frequently	☐	☐
Alcohol	☐	☐	Thoughts of Suicide	☐	☐	Speak Without Thinking	☐	☐
Caffeine	☐	☐	Sleeping Too Much	☐	☐	Waiting Your Turn	☐	☐
Frequent Vomiting	☐	☐	Sleeping Too Little	☐	☐	Completing Tasks	☐	☐
Eating Problems	☐	☐	Getting to Sleep	☐	☐	Paying Attention	☐	☐
Severe Weight Gain	☐	☐	Waking Too Early	☐	☐	Easily Distracted by Noises	☐	☐
Severe Weight Loss	☐	☐	Nightmares	☐	☐	Hyperactivity	☐	☐
Blackouts	☐	☐	Head Injury	☐	☐	Chills or Hot Flashes	☐	☐

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FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems	☐	☐	Physical Abuse	☐	☐	Depression	☐	☐
Legal Trouble	☐	☐	Sexual Abuse	☐	☐	Anxiety	☐	☐
Domestic Violence	☐	☐	Hyperactivity	☐	☐	Psychiatric Hospitalization	☐	☐
Suicide	☐	☐	Learning Disabilities	☐	☐	"Nervous Breakdown"	☐	☐

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