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________________________________

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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Empower · Strengthen · Advocate

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		

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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