● Adult Counseling Intake Form ●

Name_____ Today's Date_____

Home Address_____ (may receive mail yes/no)

City_____State_____ Zip_____

Work phone _____ (may call yes/ no; may leave message yes/ no)

Cell phone_____ (may call yes/ no; may leave message yes/no)

Email address _____ (may email yes/no)

Home Phone #_____

Date of birth_____ age _____ gender ___ male ___female

Who were you referred by? _____

Contact person in case of emergency _____

Phone # _____ Relationship _____

What kind of services are you seeking?

____Individual counseling ____Couples counseling ____ court ordered, parole, probation, mandated

____Group counseling ____Brief problem solving ____Required letter/ documentation

____Child services required

Describe your reason for seeking help.

What goals do you have for counseling?

1.

2.

3.

4.

5.

Your current occupation_____

Place of employment _____

Circle all that apply. Part time / full time / self-employed / student / returning to work

Highest level of education _____

Current religious affiliation _____

How important are spiritual matters to you? ___not ___little ___moderate ___much

Check (all that apply) how you generally get along with other people:

___affectionate ___aggressive ___avoidant ___fight/ argue often ___follower

___friendly ___leader ___outgoing ___shy/ withdrawn ___submissive

Martial status ___married ____divorced ____separated ____widowed

___ length of time ____length of time ____length of time ____length of time

___single (never married), not dating ____single (never married), dating

Sexual orientation:_____ comments: _____

Sexual dysfunction ___no ___yes (describe) _____

_____

Any current or history of being a sexual perpetrator? ___no ___yes (describe)_____

List (name and ages) those who live in your household	**List people who have had a significant impact in your upbringing & their relationship with you**
1_____	**1.**_____
2._____	**2.**_____
3._____	**3.**_____
4._____	**4.**_____
5._____	**5.**_____
6._____	**6.**_____
7_____	**7.**_____

Does anyone in your household or family suffer from alcoholism, eating disorder, depression, or anything that may be considered a mental disorder? Briefly explain.

Substance abuse status

___no history of abuse
___active abuse
___early full remission
___early partial remission
___sustained full remission
___sustained partial remission

Treatment History (include ages)

___outpatient_____
___inpatient_____
___12–step program _____
___Stopped on own_____
___other _____

Substance Abuse History

Check and complete all that apply

	Frequency	Amount
___alcohol	_____	_____
___amphetamines/ speed	_____	_____
___barbiturates/ owners	_____	_____
___caffeine	_____	_____
___cocaine	_____	_____
___crack cocaine	_____	_____
___hallucinogens (ie. LSD)	_____	_____
___inhalants	_____	_____
___marijuana or hashish	_____	_____
___nicotine/ cigarettes	_____	_____
___PCP	_____	_____
___prescription	_____	_____
___other	_____	_____

Have you ever been prescribed psychotropic medications ie. (for stabilizing moods or erratic thought patterns)? If so, what are they?

Do you currently or have you ever had thoughts of hurting yourself or someone else? Yes/ no If yes, please explain.

Have you experienced any physical or sexual abuse? If so, please explain.

Have you been to counseling before? ____no ____yes
With whom? _____
Approximately how long?_____
Was this experience helpful? ____no _____ yes
Have you ever been hospitalized for mental health reasons? _____no ____yes
Briefly explain with doctor's name and dates of hospitalization.

Military

Have you or any one close to you been in active duty in the last ten years? Yes/ no

Who? _____

How long? _____

Where? _____ Branch _____

Enlisting date _____ Rank _____

Discharge date _____

Leisure/ Recreational

Describe areas of interest or hobbies (ie. art, books, crafts, exercise, outdoor or indoor sports, church activities)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal

Are you currently involved in a custody case? ____ no ____yes If yes please explain _____

_____

Are you currently involved in a legal case? _____no ____yes If yes please explain _____

_____

Have you ever been convicted of a crime? Yes/ no If yes, please explain. _____

_____

Medical

List your primary care physician._____

Phone # _____

Address _____

Do I have permission to exchange relevant information with your doctor? yes/ no

Your signature _____

Have you had any recent surgeries or recent trips to ER? Yes/no If yes briefly explain. _____

_____

How do you rate your physical health? ____excellent ____good ____fair ____poor

Date of last doctor's visit?_____

Check if there have been any recent changes in the following

___sleep patterns ___eating disorders ___behavior ___energy level

___physical activity level ___general disposition ___weight ___nervousness/ tension

Describe changes in the areas in which you checked._____

_____

_____

_____

List current medications and dosage

List current or past major illnesses and disabilities

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking

- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns ...")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues: _____

_____

Please look back over the concerns you have checked off and circle the one that you most want help with.