

ADULT INTAKE

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Gender: _____

Address: _____

City: _____ Zip Code: _____

Email: _____ May I email you? Yes No

Cell #: _____ May I leave a message? Yes No

Home #: _____ May I leave a message? Yes No

Work #: _____ May I leave a message? Yes No

Of the contact methods above, are there any through which you DO NOT wish to be reached? _____

Religious Preference: _____ Race/Ethnic Origin: _____

Person to contact in case of an emergency:

(Name) (Relationship to client) (Phone)

Primary Care doctor: _____

(Name) (Phone)

How did you learn about me? _____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling? _____

What would you like to see happen as a result of counseling? _____

FAMILY AND RELATIONSHIP

Single Married (legally) Divorced Cohabiting Divorce in process Separated Widowed

Do you have children? Yes No *If yes, how many?:* _____ *Ages:* _____

Preference for romantic partner: Females Males Both

Are you currently in a romantic relationship? Yes No *If yes, for how long?* _____

If yes, are you satisfied with your relationship? Yes No *If no, please briefly describe current issues or stressors:*

Do you have any concerns about your safety with your partner (*e.g. domestic violence, threats, etc.*)? Yes No

If yes, please briefly describe: _____

COUNSELING AND MENTAL HEALTH

Have you been in therapy before? Yes No

If yes, for what reason did you seek therapy: _____

Approx. dates of counseling & duration: _____

Please list any previous mental health diagnoses? _____

What was **most helpful** about therapy? _____

What was **least helpful** about therapy? _____

Have you ever been hospitalized due to a mental health issue? Yes No If yes, when? _____

If yes, please describe the reason you were hospitalized: _____

Have you used psychiatric services? Yes No If yes, Doctor's Name? _____

Have taken medication for a mental health concern? Yes No If yes, please list below:

Name of medication	Dates taken	Was it helpful? (Y/N)

Are you currently hopeful about your future? Yes No

Are you currently having suicidal thoughts? Frequently Sometimes Rarely Never

Have you recently done anything to hurt yourself? Yes No

Do you have a plan to commit suicide? Yes No

Do you intend to commit suicide? Yes No

If yes, do you have the means to commit suicide? Yes No

Have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

If you checked any box other than "never," when did you have these thoughts? _____

If you checked any box other than "never," did you ever act on them? Yes No

If you have had thoughts of suicide, what positive people or things in your life give you strength to keep going?

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? Yes No

Have you previously had homicidal thoughts? Yes No *If yes, when?* _____

Have there been stressful events in your life in the last 18 months (i.e. moves, deaths, injuries, etc.)? Yes No

If yes, please describe: _____

CURRENT CONCERNS (*Please check one box for each symptom*)

<u>SYMPTOM</u>	<i>NONE</i>	<i>MILD</i>	<i>MOD</i>	<i>SEVERE</i>	<u>SYMPTOM</u>	<i>NONE</i>	<i>MILD</i>	<i>MOD</i>	<i>SEVERE</i>
Sadness					Appetite changes				
Crying					Social isolation				
Sleep disturbances					Paranoid Thoughts				
Problems at home					Poor Concentration				
Hyperactivity					Indecisiveness				
Binging/purging					Low energy				
Loneliness					Excessive worry				
Unresolved guilt					Low self worth				
Irritability					Anger issues				
Nausea/indigestion					Spiritual Concerns				
Social anxiety					Hallucinations				
Self mutilation					Racing thoughts				
Cutting					Restlessness				
Impulsivity					Drug use				
Nightmares					Alcohol use				
Hopelessness					Easily distracted				
Elevated mood					Trauma flashbacks				
Mood swings					Obsessive Thoughts				
Disorganized					Panic attacks				
Anorexia					Feeling anxious				
Grief					Feeling panicky				
Phobias					Suicidal thoughts				
Headaches					Other:				
Weight changes -unplanned									

HEALTH INFORMATION

How would you rate your **current** physical health? (*please circle one*)

Poor Unsatisfactory Satisfactory Good Very Good

Date of last physical examination: _____

Please list any chronic health problems or concerns (e.g. asthma, migraines, hyperthyroidism, chronic pain, seizures, etc.): _____

Any Allergies? Yes No *If yes, please list:* _____

Current Medications: _____

Have you ever had a head injury? Yes No

If yes, when and what happened? _____

How many hours per night do you normally sleep? _____

Are you having any problems with your sleep habits? Yes No *If yes, check where applicable:*

Sleeping too little Sleeping too much Can't fall asleep Can't stay asleep Nightmares

Do you exercise regularly? Yes No

If yes, how many times per week do you exercise? _____ *For how long?* _____

What do you do? _____

Are you having any difficulty with appetite or eating habits? Yes No *If yes, check where applicable:*

Eating less Eating more Binging Purging

Any significant weight change in the past two months? Yes No *If yes, was it planned?* Yes No

Do you drink caffeinated drinks? Yes No *If yes, # of sodas per day* _____ *# of cups of coffee per day* _____

DRUG AND ALCOHOL USE

Do you currently use alcohol? Yes No

If yes, how often do you drink? Daily _____ Weekly _____ Occasionally _____ Rarely _____

If yes, what do you typically drink (e.g. beer, wine, vodka, etc.)? _____

If yes, how much do you typically drink (e.g. two shots, one 4 oz glass) each time? _____

Do you **currently** use any drugs recreationally (e.g. marijuana, cocaine, etc.)? Yes No

If yes, what drugs do you use? _____

If yes, how often do you use? Daily _____ Weekly _____ Occasionally _____ Rarely _____

Have you used any drugs recreationally in the **past** (e.g. marijuana, cocaine, etc.)? Yes No

If yes, what drugs did you use? _____

If yes, how often did you use? Daily _____ Weekly _____ Occasionally _____ Rarely _____

Have you received any previous treatment for chemical use? Yes _____ No _____

If yes, was your treatment: Inpatient _____ Outpatient _____ Program Name: _____

Do you currently use Tobacco? Yes No

If yes, how much do you smoke/chew? _____

OCCUPATIONAL, EDUCATIONAL AND LEGAL INFORMATION

Total years of education: _____ Area of study, *if applicable*: _____

Place of Employment: _____

Occupation: _____

Are you currently employed? Yes No *If yes, are you happy at your current position?* Yes No

Please list any work-related stressors, if any: _____

Do you have financial concerns? Yes No

If yes, please explain: _____

Please list any legal issues that are currently affecting you or have had a significant impact on you in the past:

Are you currently in the military? Yes No Previously? Yes No

If yes, Branch: _____ MOS: _____ Years served _____

Deployments? _____

If yes, did you experience combat? Yes No If yes, did you experience a Traumatic Brain Injury? Yes No

FAMILY HISTORY

Are your parents: still together
 divorced, *when* _____
 separated, *when* _____
 remarried
 unmarried
 deceased, *if yes whom* _____ age(s) at death _____

Number of siblings: _____ Ages: _____

Do you have good family support? Yes No If yes, from whom? _____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Please circle "yes" for any that apply and list the family member, e.g., sibling, parent, uncle, etc.):

Difficulty		Family Member(s)
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

Did **you** experience any abuse as a **child** (physical, verbal, emotional, or sexual)? Yes No

If yes, please describe as much as you feel comfortable: _____

Did **you** experience any abuse as an **adult** (physical, verbal, emotional, or sexual)? Yes No

If yes, please describe as much as you feel comfortable: _____

OTHER INFORMATION

What would you like to work on first in therapy?

What are your overall goals for therapy?

What are effective coping strategies do you use when stressed?

Are you satisfied with your social situation/interpersonal relationships? No Yes *If no, please explain why:*

What do you consider to be your strengths/ what do you like most about yourself?

Is there anything that I did not ask about that would be important for me to know about you?