Adult Intake Form

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.

Name: _____ Today's Date: _____

Home Address: _____ (May receive mail: yes/no)

City: _____ State: _____ Zip: _____

Home Phone: _____ (May call: yes/no; May leave message: yes/no)

Work Phone: _____ (May call yes/no; May leave message: yes/no)

Cell Phone: _____ (May call yes/no; May leave message: yes/no)

Would you like to receive a discreet phone call to remind you of your appointment 24 hours in advance?

Yes No If, yes, I prefer the following telephone number to be used: Home Work Cell

Email Address: _____ (May email: yes/no)

Can we email you our newsletter or information about any upcoming seminars? Yes No

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

Marital Status: Married Never married Separated Divorced Widowed

Number of Marriages & Length of Each: _____
_____

Are you currently involved in a custody dispute? No Yes

Are you currently involved in a legal dispute? No Yes

Religious Affiliation as a Child: _____ As an Adult: _____

Occupation: _____ Education: _____

Name of Person(s) to contact in case of Emergency:
1. _____ Phone: _____
2. _____ Phone: _____

Briefly describe your reason for seeking help:
_____
_____

How did you hear about us? _____

Immediate Family Members (spouse, children) Family of Origin (parents, siblings)

Name	Age	Relationship	Name	Age	Relationship

Does anyone in your family suffer from alcoholism, and eating disorder, depression or anything that might be considered a mental disorder?
Please explain: _____

Medical Information

Primary Care Physician: Name _____

Address _____Phone _____

How would you rate your current physical health? Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches) Yes No

If yes, please explain: _____
_____

List medications you are currently taking:
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

List current illnesses or disabilities: _____
_____
_____

Past/current suicidal or homicidal thoughts/attempts? Please explain briefly.
_____
_____
_____

Physical/sexual abuse? Please explain briefly.
_____
_____
_____

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? No Yes

If so, do you feel it would be helpful for your counselor to speak with that person? No Yes

Previous Mental Health Professional/Agency: _____

Phone: _____ Dates of Service: from ____/____ to ___/____

Have you ever been hospitalized for mental health concerns? No Yes

If yes, please explain briefly (include hospital, doctor's name and dates): _____
_____
_____
_____

Current Client Concerns

Abuse (physical, emotional, sexual)	Feeling of inferiority
Abuse of non-prescription drugs	Financial problems
Adjustment to life changes (job change, move, marriage)	Health concerns
Anger	Hearing voices
Anxious (nervous, clingy, fearful, worried)	Hyperactive
Behavior problems	Inability to control thoughts
Being a parent	Insomnia (unable to sleep)
Binge/Vomit/Laxatives	Lack of motivation
Blackouts or temporary loss of memory	Learning/Academic difficulties
Bowel disturbances	Legal matters
Career choices	Lose time
Children having problems	Loss of interest in sex
Compulsive behavior	Memory
Crying spells	Nightmares
Depressed	No appetite
Difficulty having fun	Non-family relationship problems
Difficulty making friends	Palpitations
Disturbing memories (past abuse, neglect or other)	Parent/child relationship problems
Divorce	Poor home environment
Dizziness	Problem with alcohol
Drugs	Religious/Spiritual concerns
Easily distracted	Self-control
Education	Sexual identity concerns
Excessive boredom	Sexual problems
Fainting spells	Sleeping all the time
Family or Step-family relationships	Spouse problems
Fatigue	Suicidal urges
Feel lonely	Suspicious of other people
Feel panicky	Take sedatives
Feeling "numb" or cut off from emotions	Tense feelings
Feeling "on top of the world"	Thoughts of suicide
Feeling ashamed	Tremors
Feeling distant from God	Unable to relax
Feeling fat	Unable to sit still
Feeling guilt	Other _____