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# 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 ❒Cohabitating ❒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*)

| SYMPTOM | *NONE* | *MILD* | *MOD* | *SEVERE* | SYMPTOM | *NONE* | *MILD* | *MOD* | *SEVERE* |
|---|---|---|---|---|---|---|---|---|---|
| **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 ours 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?