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Adult Client Intake Form

Name: ____ Date: ________________

Birthdate: ______________________ Age: _________ Gender: ___ M ___ F

Address

____

____

Phone: _____________________________ (___H, ___ W, ___ C) Ok to leave message? ____ Y ____ N

_____________________________ (___ H, ___ W, ___ C) Ok to leave message? ____ Y ____ N

Email ____ Ok to E-Mail? ____ Y ____ N
** Please be aware that we cannot guarantee the confidentiality of e-mail communication

Marital Status: ___ Single/Never Married ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed

Children: Total Number: __________ (____ Girls, ____ Boys)

How did you hear about/find us? ____

Emergency Contact

Name: _________________________________ Relationship: _________________________

Phone: ________________________________

Have you ever had counseling/psychotherapy in the past? ____ Y ____ N
** If yes, please list the organization/name of your counselor below

____

Are you currently receiving psychotherapy/counseling services elsewhere? ____ Y ____ N
** If Yes, please list the organization/name of your counselor below

____

Please describe the events/circumstances that are brining you to seek counseling/therapy at this time

____

____

____

____

____

Please Identify any of the following symptoms you are currently experiencing

Physical

___ Fatigue
___ Racing Heart
___ Motor Ticks
___ Headaches
___ Aches and Pains
___ Shortness of Breath
___ Heart Palpitations
___ Upset Stomach/Nausea
___ Unable to Relax
___ Trembling/Shaking/Tremors
___ Changes to Sleep Patterns
___ Frequent Tension in the Body
___ Changes in Appetite/Eating Patterns
___ Changes in Sex Drive/Sexual Activity

Mental

___ Racing Thoughts
___ Obsessions (thoughts, etc.)
___ Suicidal Thoughts
___ Homicidal Thoughts
___ Recurring, Distressing Dreams
___ Distressing Dreams
___ Difficulty Concentrating
___ Hallucinations (Auditory,Visual, Etc)
___ Nightmares about Traumatic Experience(s)
___ Frequent Worry Phobias/Unusual Fears about Specific Things
___ Recurring, Distressing Thoughts about Trauma "Flashbacks" as if relivingTraumatic Experience(s)
___ Delusions (Detachment from Reality - Paranoid, Grandiosity, Etc.)

Emotional

___ Feeling Anxious or "on Edge"
___ Feeling Stressed
___ Feeling Overwhelmed
___ Feeling Panicky
___ Feeling Irritable/Angry
___ Feeling Shy
___ Feeling "Down" or "Sad"
___ Feeling Guilty

Behavioral

___ Suicide Attempt(s)
___ Drug Abuse
___ Alcohol Abuse
___ Crying
___ Lying
___ Anger Outbursts
___ Running Away
___ Withdrawal
___ Isolation
___ Blaming
___ Using/Manipulating
___ Self Harm/Mutilation

Have you been prescribed and/or taken any psychiatric medication(s) in the past? ____ Y ____ N
** If yes, please list medication(s) below

____

Are you currently prescribed and/or taking any psychiatric medication(s)? ____ Y ____ N
** If yes, please list medication(s) below

____

Please list any other medication(s) you are taking

____

____

Have you experienced significant weight change in the last 2 months? ____ No ____ Yes

Do you regularly use alcohol? ____ No ____ Yes
How often do you have 4 or more drinks in a 24-hour period? ______________________________

How often do you engage in recreational drug use?

____ Daily ____ Weekly ____ Monthly ____ Rarely ____ Never

Have you had suicidal thoughts recently?

____ Frequently ____ Sometimes ____ Rarely ____ Never

Have you had them in the past?

____ Frequently ____ Sometimes ____ Rarely ____ Never

Are you currently in a romantic relationship? ____ No ____Yes

If yes, how long have you been in this relationship? ______________________________

On a scale of 1-10, how would you rate the quality of your current relationship? ________________

Is there a history and/or current experience of domestic violence in this relationship? ____ Y ____ N
** This includes physical altercations, verbal put-downs, threats, coercion, etc.

In the last year, have you experienced any significant life changes or stressors:

____

____

____

____

Personal Mental Health History

Have you ever experienced any of the following?

Extreme depressed mood: ▫ No ▫ Yes

Extreme Mood Swings: ▫ No ▫ Yes

Rapid Speech: ▫ No ▫ Yes

Extreme Anxiety: ▫ No ▫ Yes

Panic Attacks: ▫ No ▫ Yes

Phobias: ▫ No ▫ Yes

Sleep Disturbances: ▫ No ▫ Yes

Hallucinations: ▫ No ▫ Yes

Unexplained losses of time: ▫ No ▫ Yes

Unexplained memory lapses: ▫ No ▫ Yes

Alcohol/Substance Abuse: ▫ No ▫ Yes

Frequent Body Complaints: ▫ No ▫ Yes

Eating Disorder: ▫ No ▫ Yes

Body Image Problems: ▫ No ▫ Yes

Homicidal Thoughts: ▫ No ▫ Yes

Suicide Attempt: ▫ No ▫ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): ▫ No ▫ Yes

Repetitive Thoughts (e.g., Obsessions): ▫ No ▫ Yes

Domestic Violence: ▫ No ▫ Yes

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Depression: ___ No _____ Yes - ____

Bipolar Disorder: _____ No _____Yes - ____

Anxiety Disorders: _____ No _____ Yes - ____

Panic Attacks: _____ No _____ Yes - ____

Schizophrenia: _____ No _____ Yes - ____

Alcohol/ Substance Abuse: _____ No _____ Yes - ____

Eating Disorders: _____ No _____ Yes - ____

Learning Disabilities: _____ No _____ Yes - ____

Trauma History: _____ No _____ Yes - ____

Suicide Attempts: _____ No _____ Yes - ____

Domestic Violence: _____ No _____ Yes - ____

Occupational History

Are you currently employed? ▫ No ▫ Yes

If yes, who is your current employer/position?

____

If yes, are you happy at your current position?

____

Please list any work-related stressors, if any:

____

____

____

Religious/Spiritual Information (*Leave this question blank if you would rather not answer)

Do you consider yourself to be religious? ▫ No ▫ Yes

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? ▫ No ▫ Yes

Other Information

What do you consider to be your strengths?

____

What are some refractive ways of coping that you have learned?

____

What are some goals you have for counseling?

____

____