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Adult Intake

ADULT(S) INFORMATION:
NAME:____ DOB: ____________AGE:_______
ADDRESS: ____
PHONE (HOME):_____________ (WORK): _____________ (CELL):_____________
EMAIL:____
OCCUPATION: ____

NAME:____ DOB: ____________AGE:_______
ADDRESS: ____
PHONE (HOME):_____________ (WORK): _____________ (CELL):_____________
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OCCUPATION: ____

MARITAL STATUS: Single _____Living together _____ Engaged ____ Married _
__Separated ____ Divorced _____Remarried ____ Widowed ____ Number of Years
married/living together: ____________________________________
Were there any previous marriages for either spouse: ____________
Additional Info/Duration/Children from previous relationships if applicable:
____
____
WHO IS LIVING IN YOUR RESIDENCE? ____
____
CHILDREN NOT LIVING AT HOME: ____

WHY YOU'RE HERE:
What is the problem you seek help for? How long has it existed?
____
____
____
____
____
____

FAMILY MENTAL HEALTH HISTORY: Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty: Family Member

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 ______________________________

What might contribute to the problem, i.e. the “emotional climate” in the home or community? ______________________________
____
____
____
____

Please describe previous experience with counseling including what was helpful and what was not helpful:______________________________
____
____
____

Do you or anyone in the household currently use substances? ______________
If yes please describe frequency, amount (within the last 30 days):
Cigarettes: □ No □ Yes ______________________________
Caffeine: □ No □ Yes ______________________________
Alcohol: □ No □ Yes ______________________________
Street Drugs: □ No □ Yes ______________________________
Prescription Medication (not as prescribed by physician): □ No □ Yes __________
____

Medical/Physical Health (please check all that apply and provide further explanation and/or identify family member in the space provided):

□ Dizziness/Fainting ______________________________
□ Epilepsy ______________________________
□ Sexually transmitted diseases______________________________
□ Allergies ______________________________
□ Eating problems ______________________________
□ Sleeping problems ______________________________
□ Anemia ______________________________
□ Fatigue ______________________________
□ Hearing problems ______________________________
□ Heart Problems ______________________________
□ Vision Problems ______________________________
□ Autoimmune Disease ______________________________
□ Digestive Issues ______________________________
□ Neurological Issues ______________________________
□ Reproductive Issues ______________________________
□ Other ______________________________

Current Medications (please list both prescription and over the counter medication as well as dose, frequency, and reason for medication): ____________
____
____
____

Please list and medical, mental health, or other professionals I should speak with in order to provide you with comprehensive services: ____________________
____
____

Are there special, unusual, or traumatic circumstances that impacted family members (past or current)? □ Yes □ No If Yes, please describe: _________________
____
____
____
____
____

Describe Current Social Relationships: ______________________________________

____

____

____

Describe Current Social and Leisure Activities Including Frequency: __________

____

____

____

How important to you are spiritual matters? □ Not at All □ Somewhat □ Moderate □ Very Much

Are you affiliated with a spiritual or religious group? □ Yes □ No If Yes, describe: ____

____

____

Military experience?: □ Yes □ No If Yes, describe: __________________________

____

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THANK YOU!