

Adult Intake Form

Client Name: _____

Date: _____

Address: _____

Date of Birth: _____

Gender: M F **Age:** _____

Phones: Home _____

Cell _____

Work _____

Okay to text/message? Y N

Y N

Y N

Emergency Contact Person: _____ **Phone:** _____

Insurance Name & ID #: _____ **Insurer's Name:** _____

Group #: _____ **Insurance Phone:** _____ **Insurer's Date of Birth:** _____

Form completed by (if other than client): _____

Marital Status:

- _____ Single
- _____ Living Together, Unmarried, Length of time _____
- _____ Legally Married, Length of time _____
- _____ Total number of Marriages _____

- _____ Separated, Length of time _____
- _____ Divorce in process, Length of time _____
- _____ Divorced, Length of time _____
- _____ Widowed, Length of time _____

Family Information:

RELATIONSHIP	NAME	AGE	LIVING		LIVING WITH YOU	
			YES	NO	YES	NO
Mother	_____	_____	—	—	—	—
Father	_____	_____	—	—	—	—
Spouse	_____	_____	—	—	—	—
Children	_____	_____	—	—	—	—
	_____	_____	—	—	—	—
	_____	_____	—	—	—	—

Significant Others – Please specify relationship (full, half, step siblings, grandparents, lover, ex-spouse, etc.)

_____	_____	_____	—	—	—	—
_____	_____	_____	—	—	—	—
_____	_____	_____	—	—	—	—
_____	_____	_____	—	—	—	—

Education – highest level completed:

GED Some College Bachelors PhD
 High School Associate Masters Other

Currently Enrolled in school? Y N If Yes, Where? _____

Military:

Military Experience? Y N If yes, where? _____ When? _____

Combat Experience? Y N If yes, where? _____ When? _____

Branch? _____ Discharge Date _____ Type of Discharge _____

Legal:

Any current criminal proceedings or litigations? Y N If yes, describe: _____

Any current probation or parole? Y N If yes, describe: _____

Culture/Ethnic/Religious:

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Y N If yes, describe: _____

Do you have a religious affiliation? Y N Describe: _____

Do you wish to have your spiritual beliefs incorporated into your counseling? Yes No

Explain: _____

Family History:

Have any family members or significant others had counseling or psychiatric treatment in any mental health area? Y N If yes, describe: _____

Does anyone in your family have a history of anxiety, depression or other mental health problem? Y N
If yes, describe: _____

Does/Has someone in your family, present or past, had a problem with drugs or alcohol? Y N
If yes, describe: _____

Were there special, unusual or traumatic circumstances that affected you in childhood (child abuse, sexual abuse, domestic violence, violent trauma, natural disasters, significant loss, etc.)? Describe: _____

Primary reasons for seeking services:

- | | | | |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fear/Phobias | <input type="checkbox"/> Sleeping Issues |
| <input type="checkbox"/> Parenting | <input type="checkbox"/> Stress | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Family | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Habits | <input type="checkbox"/> Mental Confusion |
| <input type="checkbox"/> Relationship | <input type="checkbox"/> Coping | <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Self Esteem/Image |
| <input type="checkbox"/> Job | <input type="checkbox"/> Grief | <input type="checkbox"/> Addictive Behaviors | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Medical/Health | <input type="checkbox"/> Crisis | <input type="checkbox"/> Anger Management | <input type="checkbox"/> Other (specify below) |
-

Please check any events that have occurred in the past 12 months:

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Job Change | <input type="checkbox"/> Natural Disaster |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Birth of Child | <input type="checkbox"/> Military combat assignment of close family member |
| <input type="checkbox"/> Moving | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Death of close family member or friend |

Counseling and mental health treatment history:

Diagnosis: _____ When? _____ Where? _____

Type of Counseling: _____ When? _____ Where? _____

Drug/Alcohol: _____ When? _____ Where? _____

Self-Help Groups: _____ When? _____ Where? _____

Psychiatric Treatment: _____ When? _____ Where? _____

Suicidal Thoughts/Attempts: When? _____

Other: _____

Do you drink alcohol? Y N If yes, how often & quantity? _____

Do you use/abuse drugs, alcohol or controlled substance? Y N If yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Y N If yes, describe: _____

Have drugs or alcohol created a problem for your job or relationships? Y N If yes, describe: _____

Please check if there have been any recent changes in the following:

- | | | | |
|--|-----------------------------------|--|--|
| <input type="checkbox"/> Sleep Patterns | <input type="checkbox"/> Behavior | <input type="checkbox"/> Energy Level | <input type="checkbox"/> General Disposition |
| <input type="checkbox"/> Eating Patterns | <input type="checkbox"/> Weight | <input type="checkbox"/> Physical activity level | <input type="checkbox"/> Nervousness/tension |

Describe any checked items above:

Medical/Physical Health:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> STD |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Problem | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bladder Control | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Other, describe: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sexual Problems | _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sleeping Disorder | _____ |

List any current health concerns or recent health or physical changes:

List any significant family history of medical problems:

Current Medications:

Prescribed Medications	Dose	Length of time	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Over-the-counter Medications				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Problematic Behaviors & Symptoms:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Spending Problems |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Judgment Errors | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Avoiding People | <input type="checkbox"/> Fears/Phobias | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Gambling | <input type="checkbox"/> Memory Impairment | <input type="checkbox"/> Disorganized Thoughts |
| <input type="checkbox"/> Cyber Addiction | <input type="checkbox"/> Sexual Addiction | <input type="checkbox"/> Mood Shifts | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pornography | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Disruptive Thoughts | <input type="checkbox"/> Social Problems |

Briefly describe how the above symptoms impact your ability to function:
