ADULT INTAKE FORM

CENTER FOR COUNSELING & FAMILY RELATIONSHIPS

Name: _____ Counselor Name: _____

Section 1: Checklist of Concerns-

Please mark all items below that are currently a significant concern:

- ❑ Addiction – substances
- ❑ Addiction – sexual/gambling
- ❑ Anger
- ❑ Anxiety
- ❑ Attention/focus
- ❑ Career concerns
- ❑ Childcare
- ❑ Chronic pain
- ❑ Decision making
- ❑ Depression
- ❑ Divorce
- ❑ Eating Disorder
- ❑ Failure
- ❑ Fatigue
- ❑ Financial troubles
- ❑ Grieving
- ❑ Guilt
- ❑ Illness or injury
- ❑ Isolation
- ❑ Lack of relationships
- ❑ Men's issues
- ❑ Mood swings
- ❑ Natural disaster
- ❑ Panic attacks
- ❑ Parenting
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination
- ❑ Relationship with partner or spouse
- ❑ Relationship with family
- ❑ Relationship with friend
- ❑ School problems
- ❑ Selfishness
- ❑ Separation
- ❑ Sleep problems
- ❑ Spiritual – relationship with God
- ❑ Spiritual – problems with religious organization
- ❑ Suicidal thoughts or attempt
- ❑ Traumatic event
- ❑ Violence
- ❑ Weight issues
- ❑ Women's Issues
- ❑ Work Issues

Look back over the concerns you have checked above. Identify your top three concerns below.

1. _____ 2. _____

3. _____

Section 2: Life Experiences-

During childhood, did any of these events have a significant impact on your life? Please mark all that apply.

- ❑ Abuse – emotional
- ❑ Abuse – physical
- ❑ Abuse – sexual
- ❑ Adopted
- ❑ Bullied
- ❑ Death or loss of someone close
- ❑ Divorce
- ❑ Domestic violence
- ❑ Family member in jail/prison
- ❑ Foster care
- ❑ Injury or illness
- ❑ Injury or illness of parental figure
- ❑ Medical/mental health concerns of caregiver
- ❑ Multiple moves
- ❑ Multiple schools
- ❑ Natural disaster survivor
- ❑ Neglect
- ❑ Parent marriage to non-biological parent
- ❑ Parental figure loss of job
- ❑ Raised by caregiver other than biological parent
- ❑ Separation from parental figure for any time period
- ❑ Substance Abuse

Section 3: Relationship History-

1. Please mark all items below that you have experienced:

❑ Living with partner	❑ Divorced	❑ Widow
❑ Married	❑ Separated	❑ N/A

2. Please mark your current status?

❑ Single	❑ Married	❑ Separated
❑ Living with partner	❑ Divorced	❑ Widow

3. Years Married _____ OR Years Living with Partner _____

4. How many biological or adopted children do you have? _____

Section 4: Emergency Contact-

In the event of a medical emergency during a session, please contact:

Name: _____

Phone Number: _____ Relationship: _____

Section 5: Employment Status-

Employer: _____ How Long with Employer: _____

Section 6: Household Information-

Please list the **Names**, **Roles** (spouse, partner, girlfriend, boyfriend, child, stepchild, etc.), and **Date of Birth** of each person who resides in the home.

1. Name: _____ Role: _____

Date of Birth: _____/_____/_____

2. Name: _____ Role: _____

Date of Birth: _____/_____/_____

3. Name: _____ Role: _____

Date of Birth: _____/_____/_____

4. Name: _____ Role: _____

Date of Birth: _____/_____/_____

5. Name: _____ Role: _____

Date of Birth: _____/_____/_____

Section 7: Spiritual History-

1. Are there spiritual beliefs and practices you follow that would be helpful for me to know about?

_____

Section 8: Medical History-

1. Primary Care Physician: _____ Phone # _____
2. When was your last physical exam? _____
3. Have you attended counseling or been hospitalized for a mental health concern in the past?

YES NO

If **YES**, please specify the year(s) and for what reason.

Year(s): _____ Reason: _____

4. Are you currently under the care of a psychiatrist? YES NO

If **YES**... Name of Psychiatrist:_____

Practice Name:_____

Section 8: Medical History (Continued)-

5. List any prescription, psychotropic, or over-the counter medications you currently use in the table below.

Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Dosage	Has it been Helpful?
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO
					0 YES 0 NO
Describe any side effects that you find troublesome from any of the medications you are currently taking.					

6. List any past or present medical conditions that you are or have been treated for.

_____

_____

7. How many hours do you exercise a week?

_____

8. How many hours do you sleep at night?

_____

9. How much caffeine do you consume in a day?

_____

10. How many times do you eat out each week?

_____