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ADULT INTAKE FORM

Client's Name (First, Middle,Last): _____

Date of Birth:_____ Age:_____

Address:_____

Tel: _____

Email:_____

Referral source: _____

Insurance:_____

Occupation (**name of company and job title**):

_____

MEDICAL HISTORY

Medication allergies or other allergies:_____

Current medication(s) (include name, dosage, frequency, and reason for taking):_____

Primary care physician's name, practice name, and tel.:_____

Have you ever been hospitalized for a mental illness? Y / N

If yes, please explain:_____

PREVIOUS MENTAL HEALTH COUNSELORS

Name of Counselor (and agency): _____

Dates of attendance and amount of time seen: _____

Issues addressed:_____

Diagnosis:_____

Outcome:_____

Have you ever been hospitalized for psychiatric reasons? Y / N

If yes, please specify how often (include dates):_____

ALCOHOL/DRUG USE AND TREATMENT HISTORY

Do you use: Cigarettes ____ Alcohol ____ Drugs _____

If yes, what kind? Specify amount and frequency per week:

_____

List drugs used within 48 hours:_____

Have you used drugs in the past? Y / N

If yes, when, how often, and what type?_____

Have you ever been hospitalized/detoxified for alcohol/use? Y / N

If yes, please specify how often (include dates):_____

Do you or others consider your drinking a problem? Y/ N

If so, who?_____

FAMILY INFORMATION

Please describe your current marital status: Married_____ Living with a Partner _____
Divorced ____Single____ Separated _____ In the process of getting divorced _____

If you are divorced, do you have custody over your children (if any)? Describe:

What is your visitation schedule (if any)?_____

Do you have frequent arguments with your spouse/partner? If yes, what are some of the most common topics of your arguments?

List any history of mental illness or addiction in immediate family (ex: depression, anxiety, manic-depression, suicide attempts, alcoholism, drugs, etc.):

_____

TRAUMA HISTORY

Do you have a history of neglect or abuse? If so, explain:

_____

Is there any specific trauma or phobia that you are interested in working on in therapy?

_____

PRESENTING PROBLEM(S)

In your view, what is your present problem for which you are seeking therapy?

_____

Describe symptoms (list frequency, duration, and intensity):

_____

Previous solutions to the problem:_____

Why are you seeking counseling for this problem now?

_____

Do your symptoms impact your daily living skills (cleaning your home, cooking meals, paying bills, taking care of children)?

_____

Are you currently experiencing problems at work, school, with family/friends?

_____

Please, list 3 treatment goals you would like to achieve in therapy.

Goal 1:_____

Goal 2:_____

Goal 3:_____

DIAGNOSTIC CHECKLIST

Please, circle all items, which you are currently or have experienced in the last three months

Suicidal thoughts, wanting to hurt oneself	Nightmares
Wanting to hurt others	Reoccurring thoughts
Has attempted suicide	Loss of sexual interest
Has threatened suicide	Need to use drugs/alcohol
Depressed	Overwhelming shame
Poor appetite or overeating	Overwhelming guilt
Low self-esteem	Feeling lonely
Feelings of hopelessness	Shaky hands
Difficulty sustaining attention on tasks or play activities	Mood swings
Feels hyperactive and restless	Loss of weight
Difficulty concentrating or making decisions; mind going blank	Unable to have fun
Feeling keyed up, restless, on edge	Muscle twitching
Easily fatigued, low energy	Can't make decisions
Irritability, outbursts of anger, often loses temper	Feeling fearful and anxious
Panic attacks	Full of energy
Difficulty falling or staying asleep or restless sleep	Crying spells
Feeling depressed and/or anxious in response to an identifiable stressor	Quick tempered
Phobic avoidance associated with the specific object or situation	Impatient with people

Other Symptoms:_____