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Adult Intake Form

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Today's Date:

Name:__________________________ ____________ Gender:_____________

Date of Birth:_____________

Home Phone:__________ Cell Phone: ____________ Email:_____________________

Address:____

Occupation:____

Current Relationship Status: ____

Please describe your partner/spouse:____

Number of Children:____

Previous Counseling History:____

Medical History (physical complains; medications):____________________________

____

How you ever witnessed or experienced violence or any type of trauma (please circle): Yes No

Do you have any suicidal thoughts or ideations (please circle): Yes No

What concerns are you currently experiencing:_____________________________

____

What are your therapeutic goals:____

____

____

____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes
Wild 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
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes

Please list any work-related stressors, if any:

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

Has anyone in your family experienced difficulties with the following:

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 ____

OTHER INFORMATION:

What do you consider to be your strengths?

____

____

____

What are effective coping strategies that you use to cope with stressful situations?

____

____

____

Client's Signature: **Date:**