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ADULT INTAKE INFORMATION

Today's Date_____ Name_____ DOB_____

Preferred Name_____ Gender_____ Ethnicity_____

Phone_____Email_____

Address_____

Relationship Status: Married Single Engaged Divorced Cohabiting Widowed

Any Limitations?_____

PRESENT LIVING SITUATION

Please fill in the following information for all of your children.

Name of Your Child	Age	Who is she/he living with?	Which school is she/he attending?

Please fill in the following information for anyone else who is living with you.

Name	Age	Relationship to You

PERSONALITY INFORMATION

As you see yourself, what kind of person are you? Describe yourself. _____

_____

_____

_____

If I were to ask other people to describe you, which five words would come up most frequently?

_____

_____

What are your greatest fears? _____

_____

_____

Identify any irrational, negative or 'horrible' thoughts that bother you: _____

_____

_____

What were your favorite things to do as a child? _____

_____

_____

How did your parent(s) typically discipline you? _____

_____

_____

Please circle any of the following that describes your family and home atmosphere as a child.

Alcoholism	Competitive	Mental Illness	Poverty	Sexual Abuse
Affectionate	Democratic	Moving Excessively	Prejudice	Stable
Angry	Distant	Neglectful	Physical Illness	Supportive
Closed	Fighting	No fun	Physical Abuse	Trusting
Cold	Frightening	Overprotective	Rigid	Other: _____

SOCIAL EXPERIENCE

Are you satisfied with your current social life? Please explain: _____

_____

_____

_____

Please describe any organized or informal social groups that you are actively involved in: _____

_____

_____

_____

When did you first begin dating? Were your early dating experiences positive? _____

_____

_____

_____

Describe your relationship with your best friend and how often you get together: _____

_____

_____

When was the last time you were together? _____

_____

Information about your childhood, schooling and friends: _____

_____

_____

EDUCATIONAL EXPERIENCE

What was the last grade in school (or degree) which you completed? _____

_____

_____

Please note any certificates, degrees or licenses which you have earned or other informal training (include approximate dates): _____

_____

Have you ever begun a training or academic program and stopped? If so, briefly describe the circumstances: _____

_____

_____

How did you do academically in school (elementary, middle, high)? _____

_____

_____

Have you ever been tested for a learning disability? _____

_____

_____

SPIRITUAL EXPERIENCE

If any, which religious or spiritual tradition do you identify with? _____

_____

_____

Please describe your family's spiritual or religious atmosphere while you were growing up:

_____

_____

_____

_____

When did you develop your current spiritual beliefs? _____

_____

_____

Do your family and friends share your current beliefs? _____

_____

_____

Identify any religious/spiritual questions or problems that are of concern to you: _____

_____

_____

Explain any recent changes in your religious life, if any: _____

_____

_____

MOOD SCALE

Please indicate your general mood level for the last month by circling one of the numbers on the scale:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Suicidal Depressed Average Good Spirits Joyful

Now mark an "L" over one of the numbers to describe the low point of your mood during the last year.

ANXIETY SCALE

Place an "X" over one of the numbers on the 1-10 scale below to indicate your general level of anxiety or nervousness over the last month. The higher the number you indicate, the higher the level of anxiety, nervousness and tension you are reporting.

1 2 3 4 5 6 7 8 9 10

Peaceful Panicky

MENTAL HEALTH HISTORY

Have you ever been in counseling or therapy before? Yes/No

If yes, when?_____ Which issues did you work on?_____

Name of counselor/therapist: _____

Have you ever been hospitalized for an emotional/mental disturbance? Yes/No

If yes, when?_____ Please describe issues and the results:_____

_____

_____

Which medications were you given?_____

_____

_____

In the last month, have you taken any medication for nervousness, depression, insomnia or pain?

Yes/No

If yes, which medication? _____

Have you ever experienced suicidal thoughts? Yes/No

If yes, please provide approximate date(s): _____

Have you ever attempted suicide? Yes/No

If yes, please provide approximate date(s): _____

Are you suicidal now? Yes/No

If yes, do you have plan? 0 _____10

No Plan Immediate Plan

Identify any habits, practices or behaviors that you would like to change: _____

_____

_____

_____

State in your own words what you consider to be the nature of your main problem(s): _____

_____

_____

_____

Describe when and how your problem(s) began: _____

_____

_____

Circle one—I estimate the severity of my problem(s) to be:

Just an Irritant	Mildly Upsetting	Moderately Severe
Very Severe	Extremely Severe	Totally Incapacitating

What have you done about it? _____

_____

_____

_____

What do you expect the counselor to do for you? _____

_____

_____

_____

Have you sought other professional help for this problem(s)? (circle one) **Yes/No**

If yes, give name(s) and professional title(s) of the therapist(s), dates of treatment(s) and results: _____

_____

_____

_____

List three goals you have for self-improvement:

1._____

2._____

3._____

List four major strengths or abilities:

1._____

2._____

3._____

4._____

Please check off all individual items that concern you:

Academic Concerns	Dreams	Health Problems	Pornography	Thoughts
Alcohol Use	Drug Use	Inferiority Feelings	Relationships Issues	Tiredness
Anger	Eating Disorders	Legal Matters	Relaxation	Unhappiness
Appetite	Education	Loneliness	Self-control	Work
Body Changes	Fears	Making Decisions	Shyness	Other: _____
Career Choices	Finances	Memory	Sleeplessness	
Depression	Friends	Nervousness	Suicidal Thoughts	

PERSONAL HISTORY

Where were you born?_____Where did you grow up? _____

How many places did you live before you finished high school?_____

How many schools did you attend through grade 12?_____

How many brothers do you have?_____How many sisters?_____Which number are you in birth order?_____

List your siblings: Name_____ Age_____

_____ _____

_____ _____

_____ _____

Please mention any step or half brothers and sisters you have:_____

_____

Were there any unusual circumstances regarding your conception or birth?_____

What is/was your mother like? How did she treat you as a child?_____

_____

What is/was your father like? How did he treat you as a child?_____

_____

Information about your parents and their marriage:_____

_____

_____

Please describe any deaths in your family while you were growing up. Please include your age(s) at the time: _____

_____

_____

Did anyone in your family attempt and/or complete suicide? **Yes/No** Who?_____

_____

Were your parents divorced or separated? **Yes/No** If yes, explain: _____

_____

_____

How old were you and how did you react? _____

_____

_____

Why did the divorce or separation occur? _____

_____

_____

With which parent did you live? _____

Please describe any head injuries, seizures and/or loss of consciousness you have had, including dates: _____

_____

Are you taking any medication for physical symptoms now? _____

_____

If yes, which medication(s) are you taking? _____

_____

Please circle if you feel:

Overweight	Underweight	Concerned About Eating Habits

Please check any of the following that apply to you:

Back Pain	Blackouts	Burning/Itchy Skin	Chest Pains
Constipation	Diarrhea	Dizziness	Don't Like Being Touched
Dry Mouth	Fainting Spells	Fatigue	Excessive Sweating
Flushes	Headaches	Hearing Problems	Indigestion
Nausea	Numbness	Overeating	Muscle Spasms
Palpitations	Seizures	Poor Appetite	Rapid Heartbeat
Tension	Tics	Skin Problems	Sleeping Too Much
Tingling	Tremors	Sleeplessness	Stomach Trouble
Twitches	Vomiting	Unable to Relax	Visual Disturbances
Watery Eyes	Weight Gain	Weight Loss	Other_____

<u>CHEMICAL SUBSTANCE USE</u>

Family use: Did/does anyone in your family of origin, or in your immediate family, use alcohol or drugs? (either prescription or street drugs)? **Yes/No**

Personal use: Which alcoholic beverages did/do you use?_____

How much?_____How often?_____

When did you have your last drink?_____

Which non-prescription drugs did/do you use?_____

When did you last use?_____

Do you use nicotine?_____ How much daily? _____ Caffeine?_____ How much daily?_____

I have done my best to answer these questions as honestly and completely as possible.

_____ _____

Client Signature Date