



Adult Intake Form

Today's Date: _____

Identifying/Contact Information:

Name: _____ Birthdate: _____ Age: _____ Sex: M F

Address: _____

County: _____ Email Address: _____

Telephone: (H) _____ (C) _____ (W) _____

Presently living with: _____

How did you hear about us?: _____

May we contact this person to thank them for the referral? Yes ___ No ___ Not Applicable ___

Emergency Contact: _____ Phone: _____

Current Situation

Briefly describe the problem that prompted you to seek counseling at this time: _____

Have there been times when the problem got better or disappeared? Yes ___ No ___

If yes, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? _____

Are there other people who play a major role in causing your problems or in helping you cope with your problems? Yes ___ No ___ Explain briefly _____

Does anyone in your family have concerns about the way anger is handled? _____

Has your partner ever pushed, shoved or hit you? _____

Is there anything else that you believe might be important for your counselor to know at this time? _____

Marital Status (Check One):

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Date of wedding: _____ Spouse's Name _____

Previous marriages:

Date of marriage	Spouse's Name	How long married	Reason for End
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children's Names and Ages

Quality of Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Education

Years of education completed: _____

Degrees received: _____

Specialized training or trade school: _____

Do you have any learning or developmental disabilities? Please specify: _____

Do you have any background/experiences in the military?____ Describe briefly _____

Occupation

Primary place of work? _____ How long there? _____

Describe the nature of your work: _____

Do you find this work satisfying?_____ Other employment: _____

Number of hours work per week: _____

Family Background

Father's Name: _____ Age _____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school: _____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of? _____

Quality of relationship currently _____

Quality of relationship in childhood _____

Mother's Name: _____ Age _____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school _____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of? _____

Quality of relationship currently _____

Quality of relationship in childhood _____

Parents were: Married(how long? _____ Divorced(when?) _____ Never Married _____

Relationship with stepparents if applicable; _____

Siblings Names and Ages

Quality of Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other noteworthy childhood relationships: _____

Significant childhood events (divorce, deaths, sickness, traumas, etc) _____

Spiritual Background

Do you regularly attend church? Yes _____ No _____ Are you an active member? Yes ___ No _____

If attending, what is the name of the church? _____

How would you characterize your current relationship with God? _____

Describe any relationships that you have presently that are supportive and encouraging for you spiritually: _____

Drug/Alcohol History

Have you recently been using alcohol or other drugs? If so, describe: _____

Have you had any problem in the following areas related to your substance use? If so, describe:

Family: _____

Friends/social: _____

Employment: _____

Financial: _____

Health: _____

Legal: _____

Self-esteem: _____

Other: _____

Describe your view of your substance use:

_____ Not a problem:

_____ Becoming a problem

_____ A severe problem

Have you ever attended:

_____ 12 step meetings

_____ Treatment program

_____ Addiction therapy

Longest period of sobriety and when: _____

How did you stay clean/sober? _____

Medical History

Describe any physical problems that require medication or physical care: _____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult your primary care physician? _____

Who is your primary care physician? (name/address) _____

Other physicians whose care you regularly receive: _____

Are you currently taking any prescription medication? Yes _____ No _____

Please list your medications here:

Name	Dosage	For what condition?	Who prescribed it?

Counseling History

Have you had previous counseling/therapy? Yes _____ No _____

If yes, when? For how long? _____

With Whom? (Name, address please) _____

Have you ever been hospitalized for a psychiatric condition? Yes _____ No _____

If yes, please describe briefly: _____

List what you feel are your supports and resources: _____

What are the goals you hope to reach through counseling? _____

Current Concerns

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate each item.

0	1	2	3	4	5	6	7	8	9	10
No concern			Moderate concern				Extreme concern			

- | | |
|--|--|
| <input type="text"/> Abused as a child | <input type="text"/> Problems with parents |
| <input type="text"/> Anger/temper | <input type="text"/> Resentment |
| <input type="text"/> Aggression | <input type="text"/> Spiritual concerns |
| <input type="text"/> Bitterness | <input type="text"/> Sexual concerns |
| <input type="text"/> Depression | <input type="text"/> Stress/anxiety |
| <input type="text"/> Difficulty in communication | <input type="text"/> Thoughts of suicide |
| <input type="text"/> Eating difficulties | <input type="text"/> Trouble making decisions |
| <input type="text"/> Education | <input type="text"/> Unhappy most of the time |
| <input type="text"/> Family problems | <input type="text"/> Use of alcohol by self |
| <input type="text"/> Fearfulness | <input type="text"/> Use of alcohol by family member |
| <input type="text"/> Financial problems | <input type="text"/> Use of drugs by self |
| <input type="text"/> Grief/loss | <input type="text"/> Use of drugs by family member |
| <input type="text"/> Marital problems | <input type="text"/> Other addiction |
| <input type="text"/> Personality conflicts | <input type="text"/> Work |
| <input type="text"/> Physical problems | <input type="text"/> Worry |
| <input type="text"/> Problems in relationships | <input type="text"/> Other (please specify) _____ |
| <input type="text"/> Problems with children | _____ |

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is
2. I worry about
3. What I do best is
4. Sometimes I feel guilty about
5. What makes me angry is
6. My biggest mistakes were
7. My job
8. What makes me nervous is
9. My personality would be better if
10. I often felt that mother
11. Jesus Christ is
12. My temper
13. My childhood
14. Prayer is
15. My biggest disappointment
16. To me, sex is
17. I would be better liked if
18. I often felt that father
19. God to me is
20. My children (child)
21. Women are
22. What hurts me most is
23. My biggest problem is
24. Men are