ADULT INTAKE FORM

CLIENT NAME: _____ **DATE:** _____

IDENTIFYING INFORMATION: *DOB _____ □ MALE □FEMALE

Identities (Ethnicity, Sexual Orientation, Religious)_____
_____

Relationship Status: □ Single □ In Committed Relationship □ Separated
□ Partnered/Married □ Cohabitating/Unmarried □ Divorced □ Widowed

Do you have any children? □ No □ Yes If Yes, how many?_____
How old?_____

Referred by: □ Self □ Friend □ Parent/Relative □ Attorney □ Other

PRESENTING PROBLEM:
_____
_____
_____
_____
_____
_____
_____

How long has this been a problem? _____

WHAT DO YOU HOPE TO EXPERIENCE WITH COUNSELING? (GOALS)
_____
_____
_____
_____

Please list your RELATIONSHIP strengths:
_____
_____
_____

CONCERNS:	**PAST**	**PRESENT/RECENT**	**EXPLAIN:**
Sleeping Concerns	□ N □ Y	□ N □ Y	_____
Weight or Eating Concerns	□ N □ Y	□ N □ Y	_____
Trauma/Abuse	□ N □ Y	□ N □ Y	_____

Alcohol Use □ N □ Y □ N □ Y _____

Drug Use □ N □ Y □ N □ Y _____

CONCERNS: **PAST** **PRESENT/RECENT** **EXPLAIN:**

Other Addictive Behaviors (Internet, Sex, Gambling…) □ N □ Y □ N □ Y _____

Current Suicidal Thoughts □ Never □ Rarely □ Sometimes □ Often

Past Suicidal Thoughts □ Never □ Rarely □ Sometimes □ Often

Suicide Attempts □ N □ Y If Yes, when: _____

Thoughts about Harming Others □ Never □ Rarely □ Sometimes □ Often

FAMILY BACKGROUND: Family Status: □ Intact □ Divorced □ Separated □ Other

Family History of Mental Illness/Other Disorders:

_____

Relationship with Mother Described As: □ Good □ Close □ Supportive □ Distant □ Strained

Relationship with Father Described As: □ Good □ Close □ Supportive □ Distant □ Strained

_____

_____

Do you feel that you currently have adequate social support? □ N □ Y Explain:

OCCUPATION:

Are you currently employed? □ Yes, full-time □ Yes, part-time □ No

If yes, how long have you been employed? _____

Occupation: _____

Are you currently receiving disability? □ Yes □ No

Have you been referred by your job's EAP service? □ Yes □ No

LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT:

Have you ever been charged with a crime, other than minor traffic offenses? □ Yes □ No

Have you ever had any involvement with the Department of Children and Families or a similar agency in another state? □ Yes □ No

Have you ever been involved in domestic violence? □ Yes □ No

Has your current relationship ever involved physical aggression or harm? □ Yes □ No

If yes, would you prefer to discuss this without your partner present? □ Yes □ No

Are you currently on probation? □ Yes □ No

MEDICAL HISTORY:

Have you ever had:

□ Major Physical injury □ Yes, one physical injury □ Yes, more than one □ No

If yes, please describe _____

□ Major Illness □ Yes, one major illness □ Yes, more than one □ No

If yes, please describe _____

How would you describe your current health? □ Excellent □ Good □ Fair □ Poor

IS THERE ANY OTHER PERTINENT INFORMATION YOU WOULD LIKE ME TO KNOW: (Academic/work issues, disability, medical problems, childhood info, legal/conduct issues, living situation, etc.)

_____

_____

_____

PREVIOUS COUNSELING/PSYCHIATRIC HISTORY:

I have had…

□ **No** Previous Treatment/Counseling □ Previous Counseling □ Psychiatric Treatment

If you have had previous counseling, how would you describe this experience?

_____

□ Past Hospitalizations (When, where, how, and how many) _____

□ Medication(s) _____

Explain any of the above:

_____

CLIENT SIGNATURE: _____ DATE: _____

COUNSELOR SIGNATURE: _____ DATE: _____