**ADULT INTAKE FORM**

**DEMOGRAPHICS**

Name: Today’s Date:

Date of Birth: Age:

Address: City, State, Zip:

Telephones: Email:

Highest Level of Education: Gender:

Occupation: Employer:

May I leave messages at any phone number listed above? Yes No

Are there others living in the home? Yes No

If so, please list below:

|  |  |
| --- | --- |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |

How are your relationships with the people living in your home?

Emergency contact:

Phone: Relationship:

Referred by:

**STRENGTHS AND CONCERNS**

What are your greatest strengths? What is going well in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your largest challenges?

Please describe the concerns that brought you here today:

When did the concerns begin?

Please list two goals you would like to address in counseling:



Please describe your sleep:

Have you experienced what you would consider trauma in your life? YES NO

**PLEASE CHECK ANY OF THE BELOW SYMPTOMS YOU ARE EXPERIENCING:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Depression |  | Feeling of extreme happiness |
|  | Trouble concentrating |  | Problems getting along with friends or family |
|  | Memory problems |  | Cold / flu |
|  | Feeling hopeless |  | Injuries |
|  | Lack of energy |  | Sexual concerns |
|  | Feeling tearful |  | Loss or Grief |
|  | Lack of enjoyment of usual activities |  | Relationship problems |
|  | Change in eating habits |  | Disordered eating |
|  | Change in sleeping habits |  | Weight changes |
|  | Changes in appetite |  | Feeling stressed |
|  | Feeling fearful |  | Easily irritated |
|  | Feeling guilty |  | Problems with anger |
|  | Feeling nervous |  | Acting violently |
|  | Obsessions or compulsions |  | Legal problems |
|  | Sudden feelings of panic |  | Thoughts of hurting self or others |
|  | Low self esteem |  | Thoughts of killing self or others |

**MEDICAL INFORMATION**

Who is your primary care physician?

Do you have any chronic medical conditions? YES NO

If so, please list:

Do you experience chronic pain? YES NO

Have you ever had any major surgeries, illness, hospitalizations? YES NO

If so, please list:

Do you have a history of headaches? YES NO

Do you have nightmares or dreams that disturb you? YES NO

Have you ever had hallucinations? YES NO

Are you currently taking any prescription of over the counter medications? YES NO

If so, please list below:

|  |  |
| --- | --- |
| MEDICATION | DOSAGE |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**SUBSTANCE ABUSE HISTORY**

Please describe any current or past use of:

Tobacco (any form)?

Alcohol?

Caffeine (any form)?

Mind-altering substances (drugs)?

Are you in drug and alcohol treatment at this time? YES NO

**COUNSELING HISTORY**

Have you ever been to counseling before? Yes No

If so, please describe each counseling experience below (most recent first):

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

Is there are history of mental health concerns or conditions in your family? YES NO

If so, please describe: