



INDIVIDUAL ADULT CLIENT INTAKE FORM

I am glad you have sought out help. I am here to assist the healing and growth process in your life. The success of that process will greatly depend on your active cooperation and participation.

In order to best serve you, please provide the following information. Your answers will remain confidential (**please print**)

Full name: _____ Birth date: _____

Address: _____

City: _____ Zip: _____

Cell Phone: _____ Work Phone _____

Home Phone _____ May I leave a message (circle one) Yes No

E-mail: _____ *Please be aware that email might not be confidential.

Marital Status: Never Married Partnered Married Separated Divorced Widowed

Spouse's name: _____ How long married? _____

Children (list names, ages, where residing): _____

Have you previously sought counseling? _____

When, and for what reason: _____

Name of therapist: _____

Have you been previously or currently prescribed psychiatric medication? No Yes

What medication? _____

For what reason? _____

For what reason do you now seek help? _____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you currently taking prescription medication for these conditions or any others?

Yes ____ No ____ What medications? _____

For what reason? _____

Do you have any other medical conditions? _____

Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

Other _____

How many times per week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? No Yes

Do you regularly use alcohol? No Yes If yes, in a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

If you used to use recreational drugs how often did you use them and how long ago?

Daily Weekly Monthly Rarely Never How long ago? _____

Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

If yes, on a scale of 0-10 with 10 as best, how would you rate the quality of your current relationship? _____

Psychological History

Have you had suicidal thoughts recently?

NOW Frequently Sometimes Rarely Never (if never, skip to next page)

If yes, do you or did you have a plan? No Yes What plan? _____

Did you have a means to carry it out? No Yes How? _____

Over **what issue** and **when** was suicide considered? _____

Have you ever attempted suicide before? _____ If so, when? _____

Has anyone you know recently committed suicide? _____

Do you have thoughts or hear voices telling you that you would be better off dead? _____

On a 0 (none) to 10 (severe) scale please put in a number indicating the depth of your feelings:

Depressed ___; Hopeless ___; Angry ___; Intent on dying ___;

Who or what is there to live for? _____

Have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

In the last year, have you experienced any significant life changes or stressors: _____

Please check any problem you have had. (If you are in a relationship, indicate what your spouse has (or had) by putting H for Husb. or W for Wife .) If the problem is one with different degrees of severity, how severe was the problem (0 = none; 10 = severe)

Issue (please check)	Past	Now	Never	How bad 0-10	When it began
Alcohol abuse					
Substance abuse					
Traumas					
Abused/neglected as a child					
Rape or sexual abuse					
Depression					
Anger					
Anxiety					
Abortion					
Divorce					
Marital infidelity					
Gay/lesbian issues					
Unresolved family issues					
Unresolved issues of grief					
Spousal abuse					
other: (please specify below)					

Have you ever experienced...	Past	Now	Never	How bad? 0-10	When it began?
Extreme depressed mood					
Wild Mood Swings					
Rapid Speech					
Extreme Anxiety					
Panic Attacks					
Phobias (to what?)					
Hallucinations					
Unexplained losses of time					
Unexplained memory lapses					
Frequent Body Complaints					
Eating Disorder					
Body Image Problems					
Repetitive Thoughts					
Repetitive Behaviors like Checking, Hand-Washing, etc					
Homicidal Thoughts					
Suicide Attempt: If so, when?					When:

FAMILY MENTAL HEALTH HISTORY:

Has anyone **in your family** (either immediate family members or relatives) **other than you** experienced difficulties with the following?

Difficulty			Family Member
Depression:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bipolar Disorder:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Anxiety Disorders:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Panic Attacks:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Schizophrenia:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Alcohol abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Substance Abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Eating Disorders:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Learning Disabilities:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Trauma History:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Suicide Attempts:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes
If yes: what is your current position? _____
Are you happy at your current position? _____
Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes
If yes, what is your faith? _____
Do you go to church? No Yes. If yes, which one? _____
How many times per month? ____ OR per year? ____

If not religious, do you consider yourself to be spiritual? No Yes
In what in what way? _____

TREATMENT PLAN INFORMATION:

What do you consider to be your strengths? (personal, family, vocational, recreation, social, cultural, community resources, etc.) _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

What are your goals for therapy?

a. _____

b. _____

c. _____

What is the first thing that you will notice that will let you know that things are getting better?

What have you tried thus far to address this problem? _____

What do you think has stopped or is stopping you from successfully addressing this problem?

What other needs do you have? (personal, family, vocational, recreation, social, cultural, community resources, etc.) _____

Is there anything else you feel it's important for me to know? _____

Client Signature

Date

(Print name) _____