

**ADULT INTAKE FORM**

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Can I leave a message for you?  YES  NO

Email: \_\_\_\_\_ Can I email you?  YES  NO

EMERGENCY CONTACT/LEGAL GUARDIAN INFORMATION

In the event of an emergency, please identify the person that I am to contact. Please inform this person that they have been identified as the client's emergency contact.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

FAMILY HISTORY

Relationship status:

Single, Not dating     Single, dating     In a Relationship     Engaged     Living with Partner

Married     Separated     Divorced     Widowed

Are you satisfied with this status:  YES  NO

Spouse / Partner Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Married:  YES  NO    Years together: \_\_\_\_\_    Are you satisfied with this relationship?  YES  NO

Describe your relationship with your spouse / partner: \_\_\_\_\_

Conflicts are due to:     Money     Friends     Communication     Employment     Sex  
 Infidelity     Legal Problems     In-Law(s)     Family     Other

Do you have any children?  YES  NO

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Describe your relationship with the mother(s)/father(s) of your child(ren): \_\_\_\_\_

Are you satisfied with this relationship: € YES € NO

Do you have siblings?

€ YES € NO

Please list their names & ages below:

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Please describe your relationship with your family members: \_\_\_\_\_

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How would you describe your parent's relationship with each other? \_\_\_\_\_

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Describe your relationship with your parent(s): \_\_\_\_\_

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Are you satisfied with this relationship:  Yes  No

What is your faith/religion: \_\_\_\_\_ Are you satisfied with this? € YES € NO

Identify plans (if any) for reconciliation, reunification, and/or involvement with your family:

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Is anyone in your family experiencing marital or relationship problems (divorce, custody, legal, financial, etc.)

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If anyone in your family has died from a health related or long-term illness, explain: \_\_\_\_\_

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How do you spend your leisure time?  With others  Alone  Equal time alone/with others

What are your leisure time activities, hobbies and interests? \_\_\_\_\_

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### MEDICAL & PHYSICAL HEALTH

Describe your current state of health: \_\_\_\_\_

Describe any medical diagnosis, disability you may have: \_\_\_\_\_

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Describe any serious illnesses or accidents: \_\_\_\_\_

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If there is a history of serious illness in your family, explain: \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_

Please record any medication(s) you are taking, the reason for its use, and how often you are taking it:

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**SUBSTANCE USE HISTORY**

*Answer the chart below for your substance use in the past 12 months.*

Substance	Never	1 or 2 times	3 - 10 times	11 - 20 times	Over 20 times	Age at first use
Alcohol (beer, wine, liquor)						
Marijuana						
Hallucinogens (LSD,PCP/angel dust, ecstasy, mushrooms)						
Opiates (heroin, morphine, codeine)						
Stimulants (cocaine, crack, speed, meth)						
Over the Counter or Prescription Misuse						
Cigarettes						
Other:						

Which alcohol/substance do you prefer? \_\_\_\_\_

Do you use alcohol and drugs together?  Yes  No  Unsure

Are you concerned about your alcohol/substance use?  Yes  No  Unsure

Have you ever tried to cut back on your use?  Yes  No  Unsure

Have you ever been annoyed/angered when questioned about your use?  Yes  No  Unsure

Have you ever felt guilty about your use?  Yes  No  Unsure

Have you ever had an 'eye-opener' to get you started in the morning?  Yes  No  Unsure

List any substance abuse treatment you have received (agency, date and duration). \_\_\_\_\_

Do you think your substance use is a problem?  Yes  No  Unsure

Explain: \_\_\_\_\_  
Describe your family's attitudes/beliefs about drugs and alcohol. \_\_\_\_\_

Describe your attitudes/beliefs about drugs and alcohol. \_\_\_\_\_

Are you concerned about the alcohol or drug use of a family member?       Yes       No       Unsure

Explain: \_\_\_\_\_

Have you or a family member ever been involved in a self-help group (NA, AA, Al-Anon, Alateen)?       Yes       No

Explain: \_\_\_\_\_

**MENTAL HEALTH HISTORY**

Please describe sources of stress: \_\_\_\_\_

How are you managing your stress? \_\_\_\_\_

Have you ever been diagnosed or treated for a mental illness (i.e. depression, anxiety, suicidal ideation, substance abuse, etc.)?

Yes     No    Describe: \_\_\_\_\_

Has anyone in your family been treated for a mental illness (i.e. depression, anxiety, suicidal ideation, etc.)?

Yes       No      Comments: \_\_\_\_\_

Have you ever destroyed or set fire to property or hurt animals?     Yes     No    Describe: \_\_\_\_\_

Are you currently having thoughts of ending your life?       Yes       No

Have you shared these thoughts with anyone?       Yes       No

Do you have a plan to end your life?       Yes       No

Do you have the means to carry out your plan?       Yes       No

Has anyone in your life committed or attempted to commit suicide?       Yes       No

Are you currently harming yourself (cutting, burning)?       Yes       No

Have you ever been in outpatient counseling, been to an inpatient treatment center, or a psychiatric hospital?

Yes     No    Describe: \_\_\_\_\_

Please list any counselor/agency that you are currently receiving services from: \_\_\_\_\_

Please select the items and concerns that may apply to you:

**Relationships**

- Marital Conflict
- Partner Conflict
- Divorce
- Parent / Parent Conflict
- Parent / Child Conflict
- Sibling Conflict
- Peer Conflict
- Getting along with others
- Difficulty beginning dating

**School / Employment**

- School Grades
- School Behavior
- School Attendance
- School work problems
- Test anxiety
- Time management
- Choosing a major
- Career exploration
- Career concerns
- Concentration
- Job Loss
- Career Transition

**Abuse**

- Abusive Relationship
- Sexual Abuse
- Emotional Abuse
- Physical Abuse
- Neglect
- Domestic Violence
- Dating Violence
- Past Abuse

**Emotion**

- Anxiety/Worry
- Depression
- Panic/Anxiety Attacks
- Fears/Phobia
- Anger
- Impulsive
- Obsessive
- Self-esteem
- Shyness
- Loneliness
- Death of loved one
- Other loss
- Sleep
- Appetite
- Tired

**Sexuality**

- Pregnancy concerns
- Pregnancy Termination concerns
- Parenting concerns
- Personal Habits
- Birth Control
- Sexual Identity
- Sexual Orientation
- Sexual Concerns

**Health**

- Weight loss/gain
- Weight Management
- Health/Medical concerns
- Disability
- Changes due to illness/injury
- Anorexia
- Bulimia

**Addictive Behavior**

- Internet use
- Instant messaging, chat rooms, bulletin board use
- Pornography
- Impulsive Shopping
- Excessive Exercising
- Gambling
- Excessive Phone/text use
- Tobacco Use
- Illegal Drug Use
- Prescription Drug Use
- Alcohol Use

**Other Concerns**

- Legal Concerns
- Housing/Residence Concerns
- Other: \_\_\_\_\_

Please identify what you would like help with first: \_\_\_\_\_

**EDUCATION**

What is the highest grade you have completed? \_\_\_\_\_

Please describe any specialized training you have received: \_\_\_\_\_

What, if any, diplomas, degrees, or certificates have you earned? \_\_\_\_\_

Are you satisfied with your education?  Yes  No

**VOCATIONAL**

Are you currently employed?  Yes  No If yes, how long at your current job? \_\_\_\_\_

Job Title: \_\_\_\_\_ Shift: \_\_\_\_\_

Are you satisfied with your job?  Yes  No

If you had the opportunity to change jobs, what type of new job would you choose? \_\_\_\_\_

\_\_\_\_\_

MILITARY SERVICE

Have you served in the Armed Forces?  Yes  No  Currently # of Years: \_\_\_\_\_

Branch of Service: \_\_\_\_\_ Months served in Active Duty: \_\_\_\_\_

Rank: \_\_\_\_\_ Discharge Type: \_\_\_\_\_

Military related disability?  Yes  No If yes, describe: \_\_\_\_\_

FINANCES

Do you use a budget to manage your monthly income?  Yes  No

Are you currently experiencing financial problems (i.e. debt collectors, repossessions, credit problems)  Yes  No

Describe: \_\_\_\_\_

What actions, if any, have been taken to resolve these financial problems? \_\_\_\_\_

\_\_\_\_\_

LEGAL HISTORY

Are you currently on probation or involved in any open court cases?  Yes  No

If yes, provide name of probation officer/caseworker and the reason for involvement \_\_\_\_\_

\_\_\_\_\_

If you have been on probation in the past, please explain \_\_\_\_\_

Are you under the jurisdiction of the court or state?  Yes  No

If yes, explain and provide the name of your caseworker \_\_\_\_\_

Has anyone in your family spent time in jail and/or prison?  Yes  No

If yes, explain \_\_\_\_\_

\_\_\_\_\_

Have you ever been in foster care?  Yes  No

Is there any additional information you would like to provide? \_\_\_\_\_

\_\_\_\_\_

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**Thank you for your time and cooperation filling out this lengthy intake. Please be assured that the information will help in formalizing our counseling sessions for the best treatment possible.**

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Client Signature(s)

Date

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Guardian Signature(s), if applicable

Date

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Donna Bright Howard MA, LLPC, NCC

Date