

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. _____

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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:

Please describe your relationship with your family members: _____

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

Describe your relationship with your parent(s): _____

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:

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

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

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

What are your leisure time activities, hobbies and interests? _____

MEDICAL & PHYSICAL HEALTH

Describe your current state of health: _____

Describe any medical diagnosis, disability you may have: _____

Describe any serious illnesses or accidents: _____

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:

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? _____

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.

Client Signature(s)

Date

Guardian Signature(s), if applicable

Date

Donna Bright Howard MA, LLPC, NCC

Date