

Adult Information Intake Form

Please print throughout this form. All information is protected as confidential.

1. Your Full Name: Date:

2. Problem Identification—Which of these issues are current problems for you?

- | | | |
|---|---|--|
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Feelings of Hopelessness | <input type="checkbox"/> Anxiety/Nervousness |
| <input type="checkbox"/> Communication Problems | <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Anger/Irritability | <input type="checkbox"/> Parent/Child Conflicts | <input type="checkbox"/> Intimacy Problems |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Academic/School Problems | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Career/Job Problems | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Alcohol/Drug Use |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Lack of Personal Goals | <input type="checkbox"/> Abuse/Abuser Issues |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Grief/Bereavement | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Self-confidence | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Other | | |

3. Person to call in case of emergency:

Relationship:

Phone Number:

4. Have you ever been in therapy before? Yes No If yes, explain:

.....
.....

5. Circle your highest level of education completed:

Grade 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5 6 7 8 9 10

6. Did you have difficulties with school or learning? Yes No If yes, explain:

.....
.....

7. Employment Status:

- full time part time self-employed unemployed homemaker student

If employed, name of employer:

Type of work:

If unemployed, are you able to work? Yes No If no, explain:

.....
.....

Print your full name here:

8. Military Service: Yes No Honorable discharge Dishonorable discharge

If dishonorably discharged, explain:

.....

9. Do you believe you have any cultural or ethnic issues that need to be explained in order for therapy to be effective?

Yes No If yes, explain:

.....

10. Were you ever abused by anyone? Yes No physically emotionally sexually

If yes, what was your age at the time of the abuse?

Who was the perpetrator?

11. Current Relational Status:

single married not married living together engaged separated

divorced widowed

In your present relationship how many years are you married (or living together)? _____

Were you ever married before and divorced? Yes No If yes, how many times? _____

12. Write a number that best describes your use next to each drug listed below:

1 (never use it) 2 (never had a problem) 3 (current problem) 4 (past history of a problem)

___ Alcohol ___ Heroin ___ Cocaine ___ Marijuana ___ Amphetamines ___ Tranquilizers

13. Do you use tobacco? Yes No Cigarettes/# packs per day _____ Pipe Cigar

Chewing tobacco

14. Which of the following have you participated in:

None AA NA GA OA Al-Anon ACOA

Other:

15. Do you have gambling or compulsive shopping problems? No gambling shopping

other, explain:

.....

16. Growing up which of the following were true for you?

Foster Care Adopted Stepfamily none of these

17. Did your parents divorce? Yes No If yes, how old were you when that happened? _____

Print your full name here:

18. How many brothers and sister did you have growing up? _____ brothers; _____ sisters

How many were half brothers/sisters? _____ Stepbrothers/sisters? _____

Where were you in the birth order? _____

19. Growing up, were any of your family members alcoholic or an abuser of other drugs? Yes No

If yes, identify family members:.....

.....

20. Did any family members have a significant illness, physical disability, or psychological problem?

Yes No If yes, explain:.....

.....

21. Are you currently living with anyone who has a significant illness, disability, psychological, or substance abuse problem?

Yes No If yes, explain:

.....

22. Have you ever experienced, witnessed, or been confronted with an event that involved actual or threatened death or injury, or threat to the physical wellbeing of yourself or others?

Yes No If yes, explain:

.....

23. What are your leisure time activities?

.....

24. Are you spiritual? Yes, I practice my religion Yes, but not practicing my religion

Somewhat spiritual No

Print your full name here:

25. This is the most important question on this intake form, so please complete it thoughtfully.
What are your goals for counseling, in other words, what do you want to achieve as a result of having
been in counseling, what outcomes do you want?

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

Continue to next page

Print your full name here:

26. Which of the following medical disorders do you presently have?

- | | | |
|---|---|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cushing's disease | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Pre-menstrual dysphoria |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> Cardiac arrhythmia | <input type="checkbox"/> Infectious hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Influenza | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Ulcerative colitis |

I have none of the medical disorders listed above.

27. List any other significant current medical problems (for example, high blood pressure, diabetes, etc)

that you have:

.....

.....

.....

28. During your birth were there any significant complications? Yes No If yes, explain:

.....

.....

.....

29. Please list all medications prescribed by a physician that you are currently taking:

Currently not taking any medication

▶ Name of Medication: Dosage:

What are you taking it for?

▶ Name of Medication: Dosage:

What are you taking it for?

▶ Name of Medication: Dosage:

What are you taking it for?

▶ Name of Medication: Dosage:

What are you taking it for?

.....
Client Signature

.....
Date