Adult Clinical Intake

Each individual participating in therapy is asked to complete this form as this will expedite the Counseling process
This information will remain confidential.

Date:________________

Client name:______________________________ DOB ______________ SSN:________________

Insured Policy Holder's Name: ______________________________ Insured DOB:________________

ID #: ______________________________________ Group # ________________

Address __________________________ City:______________ State:_______ Zip code:__________

Home phone:______________________________ Work phone:______________________________

Cell phone: ______________________________ Email:______________________________

Employed at:______________________________ Work address: ______________________________

Gross yearly income of household: <$25,000 <$50,000 <$75,000 >$75,000 Gender: Male Female

Emergency contact name: __________________________ Phone #: ______________________________

How did you hear about us?__________________________ Referred by: ______________________________

Are you currently involved in church? Yes No If yes indicate where you attend church and how frequently:

____

Relationship status: Single Married Divorced Widowed Separated Living with someone

Spouse's Name and DOB:____

Family: Do you have children? Yes No If yes provide information below:

Name	Age and DOB	Lives at

Educational background:

GED H.S. Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other

If degree applies please specify major:____

Employer:	Address	Phone

Legal history:

Have you ever been arrested? Yes No If yes indicate arrested for what and when: ________________________

Are you currently on parole or probation? Yes No

Medical history:

Do you have any significant health/medical issues? Yes No If yes what is/are the health issue(s) and are you limited in any way?

____

____

____

Date of last medical exam: ______________ Medical doctor & phone #: ______________________________

Psychiatric History: Have you attended counseling previously? Yes No

When Specify dates:	Where and with whom:	Presenting issues at that time:	Diagnosis given:

Psychotropic medications: Are you currently taking any psychotropic medications? Yes No (Specify current & past meds)

Medication	Condition	Dosage	Dates of usage	Side effects	Physician

Alcohol/drug usage: Do you currently use alcohol or drugs? Yes No

Describe the use of drugs and alcohol Type amount frequency: ______

When did you start using drugs or alcohol? ______

What has your past use of alcohol been like? ______

Suicide risk: Have you ever thought about or tried to hurt yourself? Yes No

If yes when? ______ How many times? ______

How or what did you plan to do? ______

What were the circumstances at the time? ______

Has anyone close to you ever committed suicide? Yes No If yes who how and when: ______

Abuse history: Have you ever been physically, emotionally, or sexually abused? Yes No

If yes, briefly explain (who, what and when): ______

______

______

Check the following symptoms that you have experienced in the last thirty days:

Sleep disturbance	Weight change	Tension
Withdrawal	Change in eating behavior	Lack of motivation
Physical complaints	Easily annoyed or irritated	Restlessness
Uncontrolled temper outbursts	Guilt, remorse, shame	Negativistic
Decreased sex drive	Uncontrolled/unprovoked crying	Lack of concentration
Subjective feelings of depression	Generalized anxiety	Difficulty with Decisions
Specific Anxiety	Panic attacks	Feeling as though others are watching you
Nervousness	Fear	

Support systems: Do you have people that you can turn to for support? Yes No If yes who? ______

Strengths: What do you feel are your strengths? ______

______

Presenting issues: Briefly explain why you are seeking counseling at this time: ______

______

Goals: What do you hope to achieve through counseling? ______

______

______