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Please complete the following so I can have a better understanding of how I can help you.

GENERAL INFORMATION

Date: _____Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ _____

Social Security: _____ Age: _____ Date of Birth: _____

Race: □ White □ Black □Hispanic □ Asian □ Other: _____Sex: □ Male □ Female

Relationship Status: □ Single □ Married □Divorced □ Separated

Insurance □ Yes □ No Insurance Company:_____

Insurance ID#:_____ Authorization#:_____

Insurance Address:_____

Availability (Days,Times):_____

CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: □ Yes □ No

Home Phone: (_____) _____

Mobile Phone: (_____) _____

Work Phone: (_____) _____ May We Leave a Message Here: □

Email Address: _____ May We Send Email Here: □ Yes □ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

EDUCATION INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

Are You Currently in School: □ Yes □ No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: □ Single □ Dating □ Engaged □ Married □ Separated □ Divorced □ Widowed

Adult Intake Form

Are You Content with Your Current Relational Status: □ Yes □ No. If No, Briefly Explain:

_____

If Married, How Long: _____Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: □ Mr. □ Mrs. □ Ms. □ Miss □ _____

How Long Have You Known Your Partner: _____ Age: _____

Partner's Race: □ White □ Black □Hispanic □ Asian □ Other: _____ Partner's Sex: □ Male □ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

What Words Would You Use to Describe Your Partner:

_____

Is Your Partner Supportive of You Seeking Counseling: □ Yes □ No □ Unsure □ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): □ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s)

□ Boyfriend □ Girlfriend □ Roommate □ Other: _____

CHILDREN

Name	Sex	Age	Relationship to You (natural, adopted)	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: □ Yes □ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: □ Yes □ No. If Yes, When: _____

Are There Any Custody/Visitation Issues: □ Yes □ No. If Yes, Elaborate: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Age	Relationship to You (e.g. mother, sister)	Occupation	Feelings About Relationship

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):*

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (*Use Back if Necessary*):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches…….. ☐ Past ☐ Present	Dizziness…….. ☐ Past ☐ Present	Stomach Trouble….. ☐ Past ☐ Present
Visual Trouble……. ☐ Past ☐ Present	Sleep Trouble……... ☐ Past ☐ Present	Trouble Relaxing….. ☐ Past ☐ Present
Weakness……..… ☐ Past ☐ Present	Tension……. ☐ Past ☐ Present	Rapid Heart Rate..… ☐ Past ☐ Present
Difficulty Breathing. ☐ Past ☐ Present	Intestinal Trouble….. ☐ Past ☐ Present	Hearing Noises……. ☐ Past ☐ Present
Change in Appetite.. ☐ Past ☐ Present	Tiredness…….. ☐ Past ☐ Present	Pain……☐ Past ☐ Present
Hearing Voices…… ☐ Past ☐ Present	Seeing Things……... ☐ Past ☐ Present	Other……. ☐ Past ☐ Present

Your Height: _____Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress…… ☐ Past ☐ Present	Nervousness……… ☐ Past ☐ Present	Anxiety…….. ☐ Past ☐ Present
Panic……. ☐ Past ☐ Present	Unhappiness……… ☐ Past ☐ Present	Depression……..... ☐ Past ☐ Present
Guilt…….. ☐ Past ☐ Present	Apathy…….... ☐ Past ☐ Present	Terminal Illness…..... ☐ Past ☐ Present
Recent Death……. ☐ Past ☐ Present	Grief…….. ☐ Past ☐ Present	Hopelessness…….. ☐ Past ☐ Present
Inferiority Feelings… ☐ Past ☐ Present	Defective Feelings…. ☐ Past ☐ Present	Loneliness…….. ☐ Past ☐ Present
Shyness……..… ☐ Past ☐ Present	Fears……..… ☐ Past ☐ Present	Friends…..…… ☐ Past ☐ Present
Marriage…… ☐ Past ☐ Present	Communication…..… ☐ Past ☐ Present	Physical Abuse…...… ☐ Past ☐ Present
Emotional Abuse…... ☐ Past ☐ Present	Verbal Abuse……. ☐ Past ☐ Present	Sexual Abuse……..... ☐ Past ☐ Present
Temper…….. ☐ Past ☐ Present	Anger…….. ☐ Past ☐ Present	Aggressiveness…….. ☐ Past ☐ Present
Bad Dreams……... ☐ Past ☐ Present	Concentration……... ☐ Past ☐ Present	Racing Thoughts……. ☐ Past ☐ Present
Unwanted Thoughts... ☐ Past ☐ Present	Memory……. ☐ Past ☐ Present	Loss of Control…… ☐ Past ☐ Present
Impulsive Behavior… ☐ Past ☐ Present	Self-Control……..… ☐ Past ☐ Present	Compulsivity……..…. ☐ Past ☐ Present
Sexual Problems……. ☐ Past ☐ Present	Pregnancy……..… ☐ Past ☐ Present	Abortion……...…… ☐ Past ☐ Present
Legal Matters……..... ☐ Past ☐ Present	Trauma……..…. ☐ Past ☐ Present	Eating Problems…..…. ☐ Past ☐ Present
Drug Use……. ☐ Past ☐ Present	Alcohol Use……...…. ☐ Past ☐ Present	Trouble with Job…….. ☐ Past ☐ Present

Career Choices…… ☐ Past ☐ Present	Ambition…… ☐ Past ☐ Present	Making Decisions…… ☐ Past ☐ Present
Children……..…… ☐ Past ☐ Present	Being a Parent…..…. ☐ Past ☐ Present	Finances……..... ☐ Past ☐ Present
Recent Loss……. ☐ Past ☐ Present	Disaster……..…. ☐ Past ☐ Present	Other……. ☐ Past ☐ Present

Please Elaborate on Any of the Following Above:_____

_____

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

_____

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No If Yes, Who & When:_____

CURRENT ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

_____

Complete the Following Thought: God Is_____

Do You Regularly Attend a Place of Worship: ☐ Yes ☐ No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

I have answered all questions to the best of my ability and attest the above information is true:

Signed:____ Date:_____________________________