ADULT INTAKE FORM

DEMOGRAPHICS

Name _____ Date _____

Referred by _____

Birth Date _____ Current Age _____ Gender _____

Relationship Status_____ Significant Other's Name_____

Phone Number _____ OK to leave a message? YES NO

Phone Number _____ OK to leave a message? YES NO

Email Address _____
Permission to email? YES NO

Employment Status_____ Employer_____

Position_____ Length of Employment_____

Education Experience_____

List all members and ages of your household:

FAMILY HISTORY

Describe your upbringing and your family structure growing up.

Describe the relationships among the family members in your family of origin.

Describe your relationships with your grandparents, aunts, and uncles, and other significant extended family members?

Describe your school life as a child.

Describe the best thing about your teenage self.

List any mental health diagnosis/illness/issues experienced by you or of family members.

List any drug or alcohol abuse experienced by you or of family members.

List any suicidal behaviors in your history or of family members.

List any incarcerations in your history or of family members.

List any abuse or traumas experienced by you or of family members.

List any recent important losses or deaths experienced by you or your family. (death of friend, family member, pet; loss of job or home, miscarriage, etc.)

MEDICAL HISTORY

List any general or psychiatric hospitalizations, reasons, and dates:

List all your current medication names, prescribed purpose, and dosage:

Check where applicable:

	NEVER	RARELY	SOMETIMES	OFTEN		NEVER	RARELY	SOMETIMES	OFTEN
CIGARETTES					HEART PROBLEMS				
MARIJUANA					NAUSEA				
ALCOHOL					VOMITING				
PAINKILLERS					HEADACHES				
ASPIRIN etc					BACKACHES				
COFFEE					CAN'T SLEEP				
NARCOTICS					BINGE				
STIMULANTS					PURGE				
HALLUCINOGENS					POOR APPETITE				
LAXATIVES					UNHEALTHY DIET				
COMPULSIVE EXERCISE					LACK OF INTEREST IN ACTIVITIES				
CONSTIPATION					HIGH BLOOD PRESSURE				
ALLERGIES					DIARRHEA				

List any current concerns about your physical health

OTHER INFORMATION

What are your strengths?

What do you currently do to relax and unwind?

Describe your physical life, e.g., exercise, labor, etc.

How much outdoor time do you get each day?

How much screen time are you exposed to daily?

CURRENT CONCERNS

What concern brings you in for counseling?

List your goals for counseling.

List behaviors or habits are you looking to change.

Describe any difficulties you are experiencing with your significant other.

Describe any stress currently experienced with your friends and/or coworkers.

List any other details about any stress related to your job or family life that may be helpful to your treatment.

What do you hope is going to shift after our work together?

What do you expect could get in the way of accomplishing your goal in counseling?

List any significant successes and/or failures with previous or current therapists.

List any mental illnesses in your history as well as the family history.

List any family or child criminal histories or incarcerations that are relevant.

Circle any below that apply to you:

BEHAVIORS

Difficulty concentrating	Overeating	Lack of motivation	Sleep disturbances	Aggressive behavior
Withdrawal	Working too hard	Procrastination	Suicidal ideation	Suicidal attempts
Loss of control	Crying	Obsessions	Compulsions	Impulsivity
Nervous tics	Odd behavior	Smoking	Drinking too much	Vomiting
Phobic avoidance	Temper outbursts	Risk-taking behaviors	Lack of joy	Isolation

FEELINGS

Angry	Guilty	Unhappy	Annoyed	Happy
Bored	Sad	Conflicted	Restless	Depressed
Regretful	Lonely	Anxious	Hopeless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous

PHYSICAL

Headaches	Stomach distress	Skin Problems	Dizziness	Dry Mouth
Palpitations	Fatigue	Burning/Itchy Skin	Muscle Spasms	Twitches
Chest Pains	Tension	Back Pain	Rapid Heart Beat	Sexual Disturbances
Tremors	Inability to relax	Fainting	Blackouts	Bowel disturbances
Hearing things	Excessive sweating	Tingling	Watery eyes	Visual disturbances
Hearing problems	Sensitivity to touch			

List any other information you believe would be helpful for me to know.

_____ _____

Person completing this form Date

Thanks for your time and trust,
Kathy Morgan, M.Ed., LPC