

Blue Circle Counseling

counseling·coaching·consulting

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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

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 |  |  |  |  | NAUSEA |  |  |  |  |
| MARIJUANA |  |  |  |  | VOMITING |  |  |  |  |
| ALCOHOL |  |  |  |  | HEADACHES |  |  |  |  |
| PAINKILLERS |  |  |  |  | BACKACHES |  |  |  |  |
| ASPIRIN etc |  |  |  |  | CAN’T SLEEP |  |  |  |  |
| COFFEE |  |  |  |  | BINGE |  |  |  |  |
| NARCOTICS |  |  |  |  | PURGE |  |  |  |  |
| STIMULANTS |  |  |  |  | POOR APPETITE |  |  |  |  |
| LAXATIVES |  |  |  |  | UNHEALTHY DIET |  |  |  |  |
| COMPULSIVE EXERCISE |  |  |  |  | HEART PROBLEMS |  |  |  |  |
| CONSTIPATION |  |  |  |  | LACK OF INTEREST IN ACTIVITIES |  |  |  |  |
| 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? (Include tv, video games, phone & computer) |

**CURRENT CONCERNS**

What concern brings you in for counseling?

List your goals for counseling.

List any behaviors or habits are you looking to change if not mentioned above.

Describe any difficulties you are experiencing with your significant others or family members.

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

List any other details about any stress you are experiencing 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 behavior Lack of joy Isolation

FEELINGS

Angry Guilty Unhappy Annoyed Happy

Bored Sad Conflicted Restless Depressed

Regretful Lonely Anxious Hopeless Optimistic

Energetic Relaxed Tense Envious Shame

PHYSICAL

Headaches Stomach distress Skin problems Dizziness Dry mouth

Palpitations Fatigue Burning/itchy skin Muscle spasms Twitches

Chest pains Tension Back pain Rapid heartbeat 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 important for your therapist to know.



    

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Person completing this form Date

Thanks for your time and trust,

Kathy Morgan, M.Ed., LPC