



Adult Client Intake Form

Demographics

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ Gender: _____ DOB: _____ Race: _____

Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: Single Married (____ years married) Divorced Widowed (circle one)

Children:	Name	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Referred by: _____

Therapist Church Physician Agency Friend Internet

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Previous Counseling

Have you had any previous counseling? Yes No

Name of therapist: _____ Date of counseling: _____

Would you be willing to sign a release of information to talk with previous counselor? Yes No

Medical/Mental Health Information

Physician: _____ Location: _____

Are you currently taking medication for a mental or emotional condition? Yes No

Please list conditions and medications: _____

Have you ever been hospitalized for a mental or emotional condition? Yes No

If so, please list where and when: _____

Current medical health problems and medications: _____

Are you on disability? Yes No If yes, please describe: _____

Do you currently use: Alcohol or Drugs
Never Rarely Socially Frequently Daily (circle one)

Are you in treatment (such as outpatient) or utilizing support groups (such as AA)? Yes No

If yes, please describe: _____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations?

These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups

What are some of your hobbies/interests? _____

Reasons for Seeking Counseling

In a few words, what do you think therapy is all about? _____

How long do you think therapy should last? _____

How long are you able to commit to therapy? _____

What personal qualities do you think the ideal therapist should possess? _____

Client Signature: _____ Date: _____



Please Mark All That Apply

1. Depressed mood
2. Lost interest in most activities
3. Increased appetite
4. Decreased appetite
5. Weight gain
6. Weight loss
7. Difficulty going to sleep
8. Difficulty staying asleep
9. Fatigue/ Loss of energy
10. Feelings of worthlessness
11. Inappropriate guilt
12. Difficulty concentrating
13. Preoccupation with death
14. Suicidal thoughts
15. Excessive or uncontrollable worry
16. Restlessness
17. Irritability
18. Decreased need for sleep
19. Increased talking
20. Racing thoughts
21. Distractibility
22. Elevated mood
23. Engaging in risky, pleasurable activities
24. Mood swings
25. Feelings of panic
26. Pounding heart/ Chest pains/ Shaking
27. Shortness of breath/ Dizziness/ Sweating
28. Recurrent undesirable thoughts
29. Repetitive behaviors or mental acts
30. Nausea or abdominal stress
31. Fear of losing control
32. Fear of dying
33. Recurrent intrusive memories
34. Flashbacks
35. Efforts to avoid memories
36. Fear of social situations
37. Alcohol problems
38. Drug use problems
39. Compulsive dieting
40. Vomiting/ Use of laxatives
41. Marital problems
42. Sexual problems
43. Impulsivity
44. Feeling overwhelmed
45. Anger
46. Easily upset/ On edge
47. Careless, forgetful, easily distracted
48. Difficulty organizing/ Losing things