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