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ADULT INTAKE
CONFIDENTIAL

PLEASE PRINT CLEARLY

Name _____ Birth Date _____ Gender: M/F

Home Phone _____ Cell Phone _____ Pager _____

Address _____ Social Security # _____

City _____ State _____ Zip Code _____
(Is this the address where billing should be sent? Yes ____ or No _____)

If not, where? _____

Person to contact in case of emergency _____ Phone _____

Address _____ Relation to you _____

List the persons with whom you are now living and their relationship to you (include ages of children)
_____
_____
_____

Your Occupation _____ Your Educational Level _____

Employer _____ Work Phone _____
Address _____

Length of Employment at Above _____

Spouse's Name _____ Birthdate _____ SSN _____

Spouse's Occupation _____ Employer _____
Address _____ Work Phone _____

Name of Referring Person/Party _____

I give permission for you to send a thank you note to the referring party using my name. Circle Yes or No

FAMILY BACKGROUND

Father's Name _____ If deceased, date and cause _____

Age _____ Occupation _____ Educational Level _____ Health _____

Describe his personality and relationship to you, past and present: _____
_____
_____

Mother's Name _____ If deceased, date and cause _____

Age _____ Occupation _____ Educational Level _____ Health _____

Describe her personality and relationship to you, past and present: _____
_____
_____

Parent's marital status _____ Briefly describe your parent's marriage _____
_____

How did they handle conflict in their relationship _____
_____

If divorced, when did it occur and what was your reaction to it: _____
_____

If one or both parents remarried, give date(s) and your reaction: _____
_____

Stepmother's name _____ Age _____ Occupation _____

Stepfather's name _____ Age _____ Occupation _____

Describe their personality and relationship to you, past and present: _____
_____
_____

If you were not brought up by your parents, who raised you? _____
_____ During what years? _____

How were you disciplined as a child and by whom? _____
_____

Brothers and sisters (list names, ages, marital status, occupations, and place of residence)
_____
_____

Give your impression of the home atmosphere in which you grew up, including how compatible you and everyone else were _____

As you were growing up, how as love expressed? _____

What were your parents' attitudes about sex and was there any discussion or instruction about sexuality in the home?_____
_____

Were you or your siblings ever physically and/or sexually abused, assaulted, or neglected?
_____
_____

RELATIONSHIP HISTORY

Marital Status _____ How long did you know your spouse before engagement? _____

Length of Engagement _____ Date of Marriage _____

Describe the strengths of your marital relationship_____
_____

Describe the areas of conflict in your marital relationship_____
_____

Describe your relationship with your in-laws_____
_____

List names and ages of your children/step-children and indicate which (if any) are from a previous relationship_____
_____
_____
_____

Describe any significant non-marital relationships_____
_____

Dates of previous marriage/divorces_____

RELIGIOUS ORIENTATION - SPIRITUALITY

Religious Preference _____ Place of Worship _____

Average monthly attendance _____

Describe the religious/spiritual training you experienced while growing up_____
_____
_____

WORK HISTORY (list dates, place of employment, position)

_____
_____
_____
_____

MILITARY HISTORY (List dates, location, assignment)

_____
_____
_____

CLINICAL DATA

What are your goals for counseling? (Be as specific as you can) _____
_____
_____

Previous counseling? _____ When? _____ By Whom? _____

How helpful was previous counseling? _____

Present health (circle one) Excellent Good Fair Poor

Primary Care Physician: _____
Address: _____

What serious illnesses have you had and when? _____
_____

Hospitalizations (reason/diagnosis/dates) _____
_____

Medications currently taken, dose and their purpose (include non-prescription medications, e.g. sleeping pills, diet pills, etc.) _____
_____

List any current or past history of the following for you or any family member:

Alcoholism or drug addiction: _____

Emotional Disorder: _____

Physical and/or sexual abuse or neglect _____
_____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH ARE CURRENT CONCERNS:

Moodiness	Thoughts Racing	Confused
Suicidal Thoughts	Feeling Angry	Worried, Fearful
Unhappy	Unusual Fears	Lack of Energy
Dizziness, Fainting	Problems with Eating	Frequent Sweating
Constipation or diarrhea	Chronic Health Problems	Sexual concerns
Concern about body image	Feeling Lonely	Can't Concentrate
Can't Make Decisions	Depressed	Feeling Inferior
Anxious, feeling panicky	Feelings easily hurt	No feeling at all
Unable to have a good time	Headaches	Nightmares
Fast Heart Beat	Stomach Trouble	Muscles Jumping
Cold hands, cold feet	Marital Concerns	Delusions
Need to restrict weight	Compulsive exercise	Hallucinations

Weight change gain _____ loss _____
Difficulty Sleeping too much _____ Too little _____

Overuse of drugs, alcohol, or medication	Conflict in interpersonal relations
Difficulty relating to people, making friends	Problems with children
Problems with an aging family member	Problems with parents, family

Difficulty separating from family, having own identity
Dealing with death or loss

Concern about Finances	Difficulties at work	Career Indecision
Difficulties at School	Poor Time Management	

Want to be more assertive	Develop coping skills
Clarify personal goals and values	Increase Awareness of my own feelings
Have a more realistic self expectations	Eliminate Behaviors

Spiritual issues	Conflict with Church	Feeling Guilty
Struggles with Forgiveness	Feeling Distant from God	

Other: _____

Is the information you have provided on this form true and accurate? _____

Date: _____ Signed: _____