

Adult Clinical Intake

Each individual participating in therapy is asked to complete this form as this will expedite the counseling process.
This information will remain confidential.

Date: _____

Client Name: _____ DOB: ____ / ____ / ____ SSN: _____

Relationship Status: Single Married Divorced Widowed Separated Living with Someone

Spouse's Name and DOB: _____

Family: Do you have children? Yes No If yes, provide information below:

Name	Age and DOB	Lives at

Educational Background:

GED H.S. Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other

If Degree applies, please specify major: _____

Employment History:	Employer	Dates of Employment	Reason for Leaving

Legal History:

Have you ever been arrested? Yes No If yes, indicate arrested for what and when: _____

Are you currently on parole or probation? Yes No

Medical History:

Do you have any significant health/medical issues? Yes No If yes, what is/are the health issue(s) and are you limited in any way?

Date of last medical exam: _____ Medical Doctor & Phone # _____

Psychiatric History: Have you attended counseling previously? Yes No

When (specify dates):	Where and with Whom:	Presenting Issues at that Time:	Diagnosis Given:

Psychotropic Medications: Are you currently taking any psychotropic medications? Yes No (specify current & past meds)

Medication	Condition	Dosage	Dates of Usage	Side Effects	Physician

Alcohol/Drug Usage: Do you currently use alcohol or drugs? Yes No

Describe the use of drugs and alcohol (type, amount, frequency): _____

When did you start using drugs or alcohol? _____

What has your past use of alcohol been like? _____

Suicide Risk: Have you ever thought about or tried to hurt yourself? Yes No

If yes, when? _____ How many times? _____

How or what did you plan to do? _____

What were the circumstances at the time? _____

Has anyone close to you ever committed suicide? Yes No If yes, who, how, and when: _____

Abuse History: Have you ever been physically, emotionally, or sexually abused? Yes No

If yes, briefly explain (who, what and when): _____

Check the following symptoms that you have experienced in the last thirty days:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Change in Eating Behavior | <input type="checkbox"/> Lack of Motivation |
| <input type="checkbox"/> Physical Complaints | <input type="checkbox"/> Easily Annoyed or Irritated | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Uncontrolled Temper Outbursts | <input type="checkbox"/> Guilt, Remorse, Shame | <input type="checkbox"/> Negativistic |
| <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Uncontrolled/Unprovoked Crying | <input type="checkbox"/> Lack of Concentration |
| <input type="checkbox"/> Subjective Feelings of Depression | <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> Difficulty with Decisions |
| <input type="checkbox"/> Specific Anxiety | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Feeling as Though Others are Watching You |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fear | |

Support Systems: Do you have people that you can turn to for support? Yes No If yes, who? _____

Strengths: What do you feel are your strengths? _____

Presenting Issues: Briefly explain why you are seeking counseling at this time: _____

Goals: What do you hope to achieve through counseling? _____

