

# 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: \_\_\_\_\_

Insured Policy Holder's Name: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employed at: \_\_\_\_\_ Work Address: \_\_\_\_\_

Gross Yearly Income of Household: <\$25,000  < \$50,000  < \$75,000  > \$75,000

Ethnic Origin: \_\_\_\_\_ Gender: Male  Female

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred by: \_\_\_\_\_

Are you Currently Involved in Church? Yes  No  If yes, indicate where you attend church and how frequently: \_\_\_\_\_

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:**

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

**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? \_\_\_\_\_