Adult Client Intake Form

Today's Date: _____

Name:	Age:	**Date of Birth:** **Social Security #:**
Nickname:	Gender:	
Full Address:		
Home Phone: Leave a message? Y/N	Cell Phone Leave a message? Y/N	E-mail:
Marital Status: __S ___M___W ___ D ___O	Spouse or Significant Other Name:	Preference for contact? Home Cell Email
Who lives in the house (name and ages) with you?	Does your family have any animals? If so, describe.	Do you exercise? Frequency?
Do you smoke?	Do you drink alcohol? How many times a week?	How many hours do you sleep?
Whom shall we contact in case of emergency? Relationship: **Name: _____ Phone: _____** **Physical Address: _____**		
Describe Present Health (circle best): Poor, Fair, Good, Excellent Last Medical Exam (Date):		
Current Medications & Dosages:		
Are you religious or spiritual?		
Have you ever received mental health services (psychotherapy, psychiatric services, etc.)? Please describe past counseling and counselor name. Was it helpful? Yes or No Dates of service:		
Why are you coming to counseling today? What do you hope to achieve through counseling?		
How often do you engage in recreational drug use – what is name of the drug/s: _____ □ Daily □ Weekly □ Monthly □ Infrequently □ Never		

Family Mental Health History - In this section, identify any family history of identified challenge.

	Please Circle	**Write Name of Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety/Trauma or Panic	yes/no	
Bi-Polar or Depression	yes/no	
Physical, Sexual Violence	yes/no	
Eating Disorder	yes/no	
PTSD	yes/no	
Obsessive Compulsive	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Place a check ✓ under yes or no to indicate if you currently (C), or ever experienced in the past (P) the following:

DEPRESSION	***C***	***P***	***ATTENTION or ANXIETY***	***C***	***P***
Shortness of breath; hopelessness			Avoid public places		
Chronic Sadness; Crying frequently			Trembling/shakes w/o obvious reason		
Low frustration level; irritability			Agitation		
Reduced interest/pleasure			***STRESS or TRAUMA***		
Sleeping too much/too little			Feeling detached from life/people		
Extreme high/low			Flashbacks of trauma		
SUICIDE			Easily startled/nightmares/hyper		
Recurring thoughts of death or dying			***THINKING PROBLEMS***		
Thoughts of Suicide/Plan/Action			Hearing voices/Seeing things		
Difficulty functioning: work, socially			Fearful others are talking about you		
Appetite issues; Self injury/cutting			Fearful others are plotting against you		
SUBSTANCE ABUSE			Feelings of being followed/stalked		
Health problems/Accidents - alcohol			***EATING PROBLEMS***		
Adult child of an alcoholic parent			Worry about underweight/overweight		
Excessive use of alcohol/drugs			Self-induced vomiting; restrictions		
Missing work (more than 3 x month)			Laxative or Diuretic Use		

Thank you for filling out this form. It will be reviewed with you during your first session. If there is anything else you would like for your clinician to know you may note it here:

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