Adult 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: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Referred by: _____

☐ Therapist ☐ Church ☐ Physician ☐ Agency ☐ Friend ☐ Internet

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Marital Status: Dating Engaged Married (___years married) Separated Divorced (circle one)

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

*If children are stepsiblings or partial siblings please indicate next to their name

Mental Health

Has anyone in the immediate family currently or historically been suicidal? ☐ Yes ☐ No

If yes, who and when?_____

Has anyone in the immediate family been hospitalized for mental health related issues? ☐ Yes ☐ No

If yes, who and when?_____

Is anyone in the immediate family currently receiving counseling services with another professional?

☐ Yes ☐ No If yes, who and for how long?_____

Do either you drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No

How often and what substances are used? _____

Reasons for Seeking Counseling:

_____

_____

How would you know that your time in therapy has been successful?

_____

_____

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

Client Signature: _____ Date: _____

Reflections COUNSELING GROUP

Symptom Checklist

Indicate anything that pertains to you presently:

- ❒ Anger
- ❒ Education concerns
- ❒ Sexual problems
- ❒ Work problems
- ❒ Drug use
- ❒ Loneliness
- ❒ Relationship problems
- ❒ Fatigue
- ❒ Lack of ambition
- ❒ Stomach problems
- ❒ Financial concerns
- ❒ Concerns about appearance
- ❒ Suicidal thoughts
- ❒ Fears about the future
- ❒ Problems with friends
- ❒ Problems concentrating
- ❒ Nightmares
- ❒ Quick temper
- ❒ Concerns about my thoughts
- ❒ Concerns about parenthood
- ❒ Health problems
- ❒ Concerns about age
- ❒ Nervousness
- ❒ Unable to relax
- ❒ Concerns about making decisions
- ❒ Stress
- ❒ Problems with self-esteem
- ❒ Concerns about sexual orientation
- ❒ Concerns about sexual desire
- ❒ Concerns about sexual satisfaction
- ❒ Physical abuse
- ❒ Anxiety
- ❒ Marital separation
- ❒ Lack of energy
- ❒ Feelings of inferiority
- ❒ Lack of appetite
- ❒ Sexual abuse
- ❒ Concerns about children
- ❒ Concerns about career choices
- ❒ Concerns about weight
- ❒ Shyness
- ❒ Legal problems
- ❒ Problems with self-control
- ❒ Memory difficulty
- ❒ Lack of sleep
- ❒ Under/Over-eating
- ❒ Problems with alcohol use
- ❒ Unhappiness
- ❒ Depression
- ❒ Headaches
- ❒ Fear

Other:

Indicate anything that has happened to you in the past three years:

❒ Death of a spouse/partner

❒ Death of another family member

❒ Relationship Problems

❒ Changes in relationship status

❒ Family Problems (children, in-laws)

❒ Loss of Job

❒ Move to another city or state

❒ Major illness or injury–family member

❒ Legal Problems

❒ Financial Problems

Other: _____

Additional Contributing Factors: