Adult Intake Form

Please provide the following information for your record. Information you provide here is held to the same standards of confidentiality as our sessions. Please print out this form and bring it to your first session.

Today's Date: _____/_____/_____

Referred By: _____

❑ Christy Fowler, LPC-S

❑ Erin Cameron, LPC-Intern, NCC, LCDC

CONTACT INFORMATION

Name: _____

(Last) (First) (MI)

Date of Birth: _____ /_____ /_____ **Age**: _____ **Gender**: _____ **Social Security** #: _____-_____-_____

Mailing Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____

May I leave a message? ❑ Yes ❑ No

In Case of Emergency Notify: _____ Phone: _____ Relationship: _____

If you are billing insurance for services: **Are you the insured?** ❑ Yes ❑ No

If you are not the insured, list the insured's *Name*, *Date of Birth* and ***Social Security #***:

_____ _____ /_____ /_____ _____-_____-_____

(Name) (Date of Birth) (Social Security #)

Marital Status: ❑ Never Married ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Are you currently in a romantic relationship? ❑ Yes ❑ No

If yes, for how long? _____

On a scale of 1-10 (1 = very poor, 10 = excellent), how would you rate the quality of your romantic relationship? _____

Do you have children? ❑ Yes ❑ No *If yes, how many?* _____ *Ages*: _____

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GENERAL INFO

Reasons you are seeking counseling *(be as detailed as possible)**:***

_____

_____

_____

_____

_____

_____

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION

Are you employed? ❑ Yes --- ❑ Full-Time ❑ Part-Time ❑ PRN ❑ Temporary/Seasonal ❑ No

If yes: Who is your current employer & position? _____

How long have you been employed here? _____

How would you describe your job satisfaction? ❑ Not satisfied at all ❑ Somewhat satisfied ❑ Satisfied ❑ More than satisfied ❑ Very satisfied

Please list any work-related stressors, if any: _____

_____

_____

If no: How long have you been unemployed? _____

What type of work do you do/experience do you have? _____

Are you experiencing stress over trying to gain employment? ❑ Yes ❑ No

Are you currently in the military? ❑ Yes ❑ No **Previously?** ❑ Yes ❑ No **Branch/Rank**: _____

Do you have financial concerns? ❑ Yes ❑ No

If yes, please explain: _____

_____

Highest Level of Education: 9 10 11 12 GED College - 1 2 3 4 5+ **Other Education:**_____

Do you have any legal concerns? ❑ No ❑ Yes, currently on parole/probation

If yes, please explain: _____

_____

HEALTH INFORMATION

Have you ever sought counseling or outpatient psychiatric treatment before? ❑ Yes ❑ No

If yes, what were the circumstances? Please include Provider's names and estimated dates you sought help:

_____

_____

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Was it helpful? ❑ Yes ❑ No

Have you ever been hospitalized for mental health or substance use reasons? ❑ Yes ❑ No

If yes, what were the circumstances? Please include dates: _____

_____

_____

Have you ever had a head injury? ❑ Yes ❑ No

If yes, when and what happened? _____

Primary Care Physician: _____ _____
(Name) (Phone)

Psychiatrist: _____ _____
(Name) (Phone)

When was your last full physical exam? _____ **Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.)**: _____

_____

List any medications you are presently taking and dosage: _____

_____

_____

Are you having any problems with your sleep habits? ❑ Yes ❑ No **Hours per night you normally sleep**: _____

If yes, check applicable: ❑ Sleeping too little ❑ Sleeping too much ❑ Can't fall asleep ❑ Can't stay asleep ❑ Nightmares

Are you having any difficulty with appetite or eating habits? ❑ Yes ❑ No

If yes, check applicable: ❑ Eating less ❑ Eating more ❑ Binging ❑ Purging

Have you experienced significant weight change in the last 2 months? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No

If yes, how many times per week do you exercise? _____ *For how long?* _____

If yes, what do you do? _____

SUBSTANCE USE INVENTORY

Please check the appropriate boxes regarding current or past substance use. *If you are unsure of a substance, ask your counselor.*

Alcohol:	❑ Current ❑ History ❑ Never	**Ecstasy/MDMA:**	❑ Current ❑ History ❑ Never
Marijuana:	❑ Current ❑ History ❑ Never	**Bath Salts:**	❑ Current ❑ History ❑ Never
Synthetic Marijuana:	❑ Current ❑ History ❑ Never	**PCP:**	❑ Current ❑ History ❑ Never
Hallucinogens:	❑ Current ❑ History ❑ Never	**Inhalants (e.g., glue, gas):**	❑ Current ❑ History ❑ Never
Sedatives/Hypnotics:	❑ Current ❑ History ❑ Never	**Kratom:**	❑ Current ❑ History ❑ Never
Benzodiazepines/Anxiolytics:	❑ Current ❑ History ❑ Never	**Heroin/Opiates:**	❑ Current ❑ History ❑ Never
Cocaine/Crack:	❑ Current ❑ History ❑ Never	**Prescription Opioids:**	❑ Current ❑ History ❑ Never
Methamphetamine:	❑ Current ❑ History ❑ Never	**Over-the-Counter Medications:**	❑ Current ❑ History ❑ Never
Amphetamines:	❑ Current ❑ History ❑ Never	**Nicotine (e.g., cigarettes, vaping):**	❑ Current ❑ History ❑ Never

Caffeine: ❑ Current ❑ History ❑ Never **Other:** _____ ❑ Current ❑ History ❑ Never

Have you used substances to ease difficulties with emotions, relationships, or as a stress reliever? ❑ Yes ❑ No

What is your perception of your current substance usage? ❑ Not a problem ❑ Unsure if problem ❑ Some problem ❑ Significant problem ❑ Severe problem ❑ Actively wants help

Please explain any areas of your life are affected by problematic use: _____

_____

Counselor may implement additional brief screening tools to explore any problematic substance use – if indicated above

---

FAMILY HISTORY

Are your parents: ❑ still together? ❑ remarried? ❑ unmarried? ❑ divorced? ❑ deceased?

Do you have siblings? ❑ Yes ❑ No *If yes, how many?* _____ *Ages*: _____

Do you have good family support? ❑ Yes ❑ No *From whom?* _____

_____

Do you have any problematic family relationships? ❑ Yes ❑ No *With whom?* _____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?
(circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member(s)**
Depression	❑ Yes ❑ No	_____
Bipolar Disorder	❑ Yes ❑ No	_____
Anxiety Disorders	❑ Yes ❑ No	_____
Panic Attacks	❑ Yes ❑ No	_____
Schizophrenia	❑ Yes ❑ No	_____
Substance Abuse	❑ Yes ❑ No	_____
Eating Disorders	❑ Yes ❑ No	_____
Learning Disabilities	❑ Yes ❑ No	_____
Trauma History	❑ Yes ❑ No	_____
Suicide Attempts	❑ Yes ❑ No	_____
Psychiatric Hospitalizations	❑ Yes ❑ No	_____

RISK OF HARM ASSESSMENT

Have you *ever* had thoughts about suicide? ❑ Yes ❑ No

Do you currently have thoughts of suicide? ❑ Yes ❑ No

If yes, do you have a plan? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

If yes, how many times? _____

How long ago? _____

Have you *ever* had thoughts of harming someone else? ❑ Yes ❑ No

Do you currently have thoughts of harming someone else? ❑ Yes ❑ No

If yes, do you have a plan of how to inflict harm? ❑ Yes ❑ No

If no, how long ago? _____

Have you ever engaged in self-harming behaviors? ❑ Yes ❑ No

Do you currently engage in self-harming behaviors? ❑ Yes ❑ No

*Please explain how you self-harm:*_____

_____

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LIFE EVENTS CHECKLIST (LEC)

Listed below are several difficult or stressful things that sometimes happen to people. For each event, check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

	Event Happened to Me	Witnessed It	Learned about It	Not Sure	Doesn't Apply
Natural disaster	❑	❑	❑	❑	❑
Fire or explosion	❑	❑	❑	❑	❑
Transportation accident	❑	❑	❑	❑	❑
Exposure to toxic substance	❑	❑	❑	❑	❑
Physical assault	❑	❑	❑	❑	❑
Assault with a weapon	❑	❑	❑	❑	❑
Sexual assault	❑	❑	❑	❑	❑
Other unwanted or uncomfortable sexual experience	❑	❑	❑	❑	❑
Combat or exposure to a war-zone	❑	❑	❑	❑	❑
Captivity	❑	❑	❑	❑	❑
Life-threatening illness or injury	❑	❑	❑	❑	❑
Severe human suffering	❑	❑	❑	❑	❑
Sudden, violent death	❑	❑	❑	❑	❑
Serious injury, harm, or death you caused to someone else	❑	❑	❑	❑	❑
Any other very stressful event	❑	❑	❑	❑	❑

PRESENTING SYMPTOMS/CONCERNS

	Time of Concern			Amount of Distress		
	Current	Past	Never	Often	Sometimes	Never
Depressed Mood or Sadness	❑	❑	❑	❑	❑	❑
Irritability/Anger	❑	❑	❑	❑	❑	❑
Mood Swings	❑	❑	❑	❑	❑	❑
Excessive Worrying	❑	❑	❑	❑	❑	❑
Poor Impulse Control or Risky Behaviors	❑	❑	❑	❑	❑	❑
Panic Attacks	❑	❑	❑	❑	❑	❑
Phobias	❑	❑	❑	❑	❑	❑
Poor Self Esteem	❑	❑	❑	❑	❑	❑
LGBTQ+ Identity Conflict	❑	❑	❑	❑	❑	❑
Body Image Problems	❑	❑	❑	❑	❑	❑
Hallucinations	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑
Lack of Motivation	❑	❑	❑	❑	❑	❑
Changes in Energy Level	❑	❑	❑	❑	❑	❑
Problems with Bosses/Teachers/Authorities	❑	❑	❑	❑	❑	❑
Conflicts in Friendships/Social Problems	❑	❑	❑	❑	❑	❑
Social Anxiety	❑	❑	❑	❑	❑	❑
Distractibility/Concentration/Attention Problems	❑	❑	❑	❑	❑	❑
Family Communication Problems	❑	❑	❑	❑	❑	❑

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Death or Major Illness of a Loved One	❑	❑	❑	❑	❑	❑
Marriage/Relationship Conflicts	❑	❑	❑	❑	❑	❑
Adjusting to Divorce or Separation	❑	❑	❑	❑	❑	❑
Parental Stress	❑	❑	❑	❑	❑	❑
Single Parenting or Step-parenting Problems	❑	❑	❑	❑	❑	❑
Loneliness	❑	❑	❑	❑	❑	❑
Health Issues	❑	❑	❑	❑	❑	❑
Job Loss	❑	❑	❑	❑	❑	❑

OTHER INFORMATION

What role, if any, does religion and/or spirituality play in your life? _____

_____

Are you satisfied with your level of social interaction/interpersonal relationships? ❑ Yes ❑ No

If no, explain why: _____

_____

_____

What do you consider to be your strengths? What do you like most about yourself? _____

_____

_____

In the last year, have you experienced any significant life changes or stressors? _____

_____

_____

_____

What are effective coping strategies you use when stressed? _____

_____

What are your overall goals for therapy? What do you hope to gain from the sessions? _____

_____

_____

_____

Is there anything that I did not mention on this form that would be important for me to know about you? _____

_____

_____

I hereby give consent that the information that I have provided is accurate to my current knowledge. I understand that this information will only be used in the direct delivery of services and means of communication with my counselor.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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