INTAKE FORM - ADULT

To Be Filled Out by the Client

Name: _____ Birth Date: _____ Date:_____

May we contact you by phone? Yes No

May we leave a message? Yes No

May we contact you by mail? Yes No

May we remind you by email? Yes No

Symptoms: If you have experienced a change in any of the following, please indicate an increase with an UP arrow or a decrease with a DOWN arrow:

sleep____ appetite___ energy____ motivation____ concentration____ sex___ exercise___ weight ____

anxiety____ worry___ pleasure____ anger____ sadness ____ stress ____ helplessness____ depression____

self-esteem____ hopelessness____ irritability_____ other _____

Have you ever been diagnosed with a mental illness? Yes No

Diagnosis:_____

Do any relatives have a known mental illness? Yes No

Who/Diagnosis:_____

Have you had previous counseling? Yes No

Who/When:_____

Are you currently taking any medications: Yes No

If yes, please list:

Medication:	Taken For:	Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you currently feel suicidal? Yes No

Have you been suicidal in the past? Yes No

Have you ever attempted suicide? Yes No

Do you currently self-injure? Yes No

History of self-injury? Yes No

Do you currently use drugs of any kind? Yes No

Do you have a history of drug use? Yes No

If yes, what drugs: _____

Do you currently use alcohol? Yes No

Do you have a history of alcohol use? Yes No

If yes, list frequency: _____

Have you ever experienced any of the following? Please circle all that apply:

Trauma Miscarriage Abortion Physical Abuse Emotional Abuse

Sexual Abuse Sexual Assault/Rape

Briefly Describe (if you wish):_____

_____

_____

What do you want to accomplish in counseling?

_____

_____

_____

_____

_____