



ADULT INTAKE FORM

We appreciate the opportunity to serve your counseling needs. Please take a few moments to provide us with the following information:

Personal Information

Date: _____

Client's Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we call you and leave messages at home? Yes No At work? Yes No
May we send mail to you at this address? Yes No If not, mailing address is _____

Occupation: _____ Highest Level of Education: _____

Marital Status: Single Married Divorced Widowed Date of Current Marriage: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Occupation: _____ Spouse's Level of Education: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

Approximate Gross Family Income Per Year: \$ _____ Number of hours per week you work? _____

Briefly describe your reason(s) for seeking help:

What would you like to accomplish during this or these helping sessions?

This is strictly confidential patient medical record. Redislosure or transfer is expressly prohibited.

Medical History

How would you rate your current physical health: Excellent Good Fair Poor

When did a physician last examine you? _____ Name of Physician: _____

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? Yes No

If yes, please explain: _____

List any medications and dosage you are now taking:

Medication(s) Over-the-counter or Prescription	Dosage

Counseling and Psychiatric History

Have you had previous psychiatric or psychological help or counseling of any kind before? Yes No

If yes, when? _____ For how long? _____

Please describe reason(s) _____

Name and Location of counselor: _____

Please rate the severity of your present concerns on the following scale. Check one:

Mild Moderate Severe Totally Incapacitating

Who referred you to HOPE Network? Friend Church Pastor Other: _____

Spirituality

Do you believe in God? Yes No

What is your religious preference? _____

Are you a member of a church? Yes No

If yes, what church? _____

Meaningfulness of your faith/religion: Good Fair Poor

How much influence does your religion/faith have on your day-to-day activity?

A Lot Moderate Little None

Emergency Contact

Name: _____ Phone number: _____

I (We), the responsible party (parties), acknowledge that copies of the Declaration of Practices and Procedures, and the sliding fee scale were provided to me (us).

Client's Signature(s): _____ Date: ____/____/____.

_____ Date: ____/____/____.

Please indicate which of the following areas are currently problems for you. Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Feeling inferior to others | <input type="checkbox"/> Not being able to say what you really think or feel |
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Communication/conflict resolution |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood | <input type="checkbox"/> Excessive fear of specific places or objects |
| <input type="checkbox"/> Excessive anxiety or worry | <input type="checkbox"/> Difficulty making friends or keeping friends |
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Remarriage/Blended family |
| <input type="checkbox"/> Suspicious feelings toward other people | <input type="checkbox"/> Feeling as if you'd be better off dead |
| <input type="checkbox"/> Afraid of being on your own | <input type="checkbox"/> Feeling manipulated or controlled by others |
| <input type="checkbox"/> Angry feelings or outbursts | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Concerns about finances | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Feeling "numb" or cut off from emotions | <input type="checkbox"/> Feeling sexually attracted to members of your own sex |
| <input type="checkbox"/> Concerns about physical health | <input type="checkbox"/> Feeling distant from God |
| <input type="checkbox"/> Concerns about emotional stability | <input type="checkbox"/> Hallucinations/Delusions |
| <input type="checkbox"/> Work/Career | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Spiritual issues (church/ministry) | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Suicidal thoughts, feelings, actions | <input type="checkbox"/> Difficulty sleeping (too much, too little) |
| <input type="checkbox"/> Loss of appetite/increased appetite | <input type="checkbox"/> Inability to concentrate while at school/work |
| <input type="checkbox"/> Uncontrollable anxiety or worry | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Lacking self-confidence | <input type="checkbox"/> Feeling "on top of the world" |
| <input type="checkbox"/> Feeling fat | <input type="checkbox"/> Loss of interest in usual activities/lack of motivation |
| <input type="checkbox"/> Eating and then vomiting to control weight | <input type="checkbox"/> Obsessions or compulsions with specific activities, places, objects |
| <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Inability to control thoughts |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Feeling trapped in rooms/buildings |
| <input type="checkbox"/> Getting into trouble at school/work | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Spousal abuse |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Drug addiction, abuse, dependency | <input type="checkbox"/> Relational problems |
| <input type="checkbox"/> Parent- child conflict | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Attention Deficit or Hyperactivity | <input type="checkbox"/> Conduct problems with children |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Marriage issues | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Traumatic events | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Child custody issues | |
| <input type="checkbox"/> Feeling that people are "out to get you" or that you are being watched | |
| <input type="checkbox"/> Other: _____ | |