ADULT INTAKE FORM TODAY'S DATE: ___________

NAME & IDENTIFYING INFORMATION:

Name (First, MI, Last): ____________________________________ Nickname: _____________________
DOB: ____/____/_______ Age: ______________ Sex: Male______ Female_____ TG ________
Marital Status: Single ____ Married ______ In a Relationship _____ If so, for how long? _____________
Employment Status: Employed ______ Student ________ Other _________________________________
Employer: ____________________________________ Occupation: _______________________________
Spouse Name: ____ Date of Birth: _______________________
Spouse Employer: ____________________________ Spouse Occupation: __________________________
Do you have children? _____ If so, list ages and gender: ____
Whom may we thank for referring you? ____

ADDRESS & CONTACT INFORMATION:

Street Address: ____
City: ____ State: _________ Zip Code: ________________
In case of emergency, who should we notify? _________________________ Phone: ___________________
May we contact you by phone: Home _____ Mobile _____ Work ______ Email ______________________
Home/Mobile number: ______________________________ Work number: __________________________
Email Address: ____

____I agree that Phelps Counseling, Consulting & Training may communicate with me electronically (via Email) unless and until I revoke this authorization by submitting notice to us in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for it to be disclosed to third parties.

INSURANCE INFORMATION:

Primary Health Insurance Company: ________________________________ Individual ____ Family _____
Insurance Company Claims Address: ____
Phone # _____________________ Policy # ___________________¬¬___________ Group # ____________
Policy Holder's Name & Address: ____
Policy Holder's Date of Birth: ___/___/________ Policy Holder's Employer: _________________________
May we submit information to your insurance company that is necessary to receive payment? ____________

MEDICAL INFORMATION & HISTORY:

Primary Care Physician Name: ________________________________ Phone #: ________________________
Primary Care Physician Address: ____

Starting with childhood, list all diseases. Important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment Received	Treated by	Result

Describe any allergies you have.

Allergy:	Reaction:

List all medications or drugs you take or have taken in the last year (prescribed, over-the-counter, and others.)

Medications/Drug:	Dose:	Taken for:	Prescribed/Supervised by:

Date of last physical exam: ____

Have you received mental health treatment previously? Yes_____ No_____ If yes, please explain:

Treatment Type	When	Provider/Program	Reason for Treatment
Outpatient counseling			
Psychiatric (Medication)			
Psychiatric Hospitalization			
Drug/Alcohol Treatment			
Self-help/Support Group			

RELATIONSHIP HISTORY AND CURRENT FAMILY:

☐ Straight/heterosexual ☐ Bisexual ☐ Unsure/questioning ☐ Prefer not to answer
☐ Gay/homosexual ☐ Transsexual ☐ Asexual ☐ Other: _______________

Describe your relationship with your spouse or significant other: ________________________________
Have you had any prior marriages? ______ If so, how many? ________ For how long? ________________
Describe your relationship with your children: ____
List everyone who currently lives with you: ____

PRESENTING PROBLEMS AND CONCERNS:

Please mark all of the behaviors and symptoms that you consider problematic:

- □ Parenting/Relationship
- □ Impulsive/Compulsive
- □ Panic Attacks
- □ Guilt/Shame
- □ Withdrawal from people
- □ Unmotivated
- □ Low self-worth
- □ Alcohol/Drug use
- □ Increased risky behavior
- □ Sleeping/Nightmares
- □ Avoidance
- □ Racing thoughts
- □ Wide Mood Swings
- □ Sadness/Depressed
- □ Suspicion/Paranoia
- □ Hopelessness
- □ Concentration/Forgetful
- □ Social discomfort
- □ Flashbacks
- □ Fatigue
- □ Change in appetite
- □ Thoughts of death
- □ Obsessive thoughts
- □ Self-harming
- □ Seeing/Hearing things
- □ Computer addiction
- □ Hyperactivity
- □ Pornography
- □ Gambling problems
- □ Change in Libido
- □ Anxiety/Worry
- □ Other: ______

ARE YOUR PROBLEMS AFFECTING ANY OF THE FOLLOWING?

- □ Handling everyday tasks
- □ Health/Hygiene
- □ Legal Matters
- □ Self-esteem
- □ Work/School
- □ Recreational activities
- □ Relationship/Sexual Activity
- □ Housing/Finances
- □ Other: ______________

Have you ever had feelings or thoughts that you didn't want to live? ______________________________

If yes, how often and when was the last time you had these thoughts? ______________________________

Has anything happened recently to make you feel this way? ______________________________

On a scale of 1 – 10 (10 being strongest) how strong is your desire to kill yourself currently? ______________________

Have you thought about how and when you would kill yourself? ______________________________

Is the method you would use readily available? ______________________________

Have you ever tried to kill or harm yourself before? ______________________________

Do you have access to guns? ____________ If yes, please explain ______________________________

Have you recently been physically hurt or threatened by someone else? If yes, please explain: ______________________

____

Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please explain ______________

____

How often do you have these thoughts? ______________________________

On a scale of 1 – 10 (10 being strongest) how strong is your desire to kill/hurt someone currently? ________________

Have you ever thoughts about how and when you would kill someone else? ______________________________

Is the method you would use readily available? ______________________________

Have you ever tried to kill or harm someone else before? ______________________________

ARE YOUR PROBLEMS AFFECTING ANY OF THE FOLLOWING?

- □ Emotional abuse
- □ Violence in the home
- □ Homelessness
- □ Sexual abuse
- □ Crime victim
- □ Loss of a loved one
- □ Physical abuse
- □ Parent illness
- □ Financial problems
- □ Parent abuse
- □ Place a child in adoption
- □ Miscarriage/Stillborn
- □ Teen pregnancy
- □ Lived in a foster home
- □ Other: _____________
- □ Neglect
- □ Multiple family moves

FAMILY MENTAL HEALTH HISTORY:

Please note if any family members have had any of the following mental health problems:

Mental Health History Who?

ADHD ____________________
Sexual Abuse ____________________
Depression ____________________
Bipolar Disorder ____________________
Suicide Attempt/Self-harm Behaviors ____________________
Anxiety Problems/Panic Attacks ____________________
OCD ____________________
Anger/Abusive Behaviors ____________________
Schizophrenia ____________________
Eating Disorder ____________________
Drug/Alcohol Abuse ____________________
Autism ____________________
Other ____________________

SUBSTANCE USE HISTORY

Have you had withdrawal symptoms when trying to stop using any substances? ____________________
If yes, please describe: ____________________
Have you gambled in the past 6 months? ____________________
If yes, have you ever felt the need to bet more and more money? ____________________
Have you ever had to lie to people important to you about how much you gambled? ____________________
Have you had problems with work, relationships, health, the law, etc. from substance abuse? ____________________
If yes, please describe: ____________________

Substance Current Use (last 6 months): Frequency Amount Past usage

Tobacco ____________________
Caffeine ____________________
Alcohol ____________________
Marijuana ____________________
Cocaine/Crack ____________________
Ecstasy ____________________
Heroin ____________________
Inhalants ____________________
Methamphetamines ____________________
Pain Killers ____________________
PCP/LSD ____________________
Steroids ____________________
Tranquilizers ____________________

FAMILY MENTAL HEALTH HISTORY:

Please describe your social support network

☐ Family ☐ Friends/Students ☐ Community Group
☐ Neighbors ☐ Co-workers ☐ Other: ___________________________
☐ Support/Self-help group ☐ Religious/Spiritual Center

To which cultural or ethnic group do you belong? ____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: ______________________________
____

How important are spiritual matters to you?

☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs to be incorporated into your counseling? _________________________________
Please describe your strengths, skills, and talents? ____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _________________________________
____

MISCELLANEOUS INFORMATION:

What is the highest level of education you have received? ____
School Attended: ____
Have you been/are you currently in the military? ____
Branch: ____ Rank: ____
Date of discharge: ______________________________________ Type of discharge: __________________________________
How would you describe the impact of your military experience? ____
____

LEGAL HISTORY:

Have you ever been arrested? __________________Do you have any pending legal problems? _______________________
Have you ever been convicted of a misdemeanor or felony? ____
If yes, please explain: ____
Are you currently involved in any divorce or child custody proceedings? ____
If yes, please explain: ____

Signature: ____ Date: ____