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COUNSELING, CONSULTING & TRAINING, LLC

ADULT INTAKE FORM

TODAY'S DATE: _____

NAME & IDENTIFYING INFORMATION:

Name (First, MI, Last): _____ Nickname: _____
DOB: ____/____/_____ Age: _____ Gender:_____
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? _____

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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:

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: _____

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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	

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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 _____

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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: _____