Adult Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

1) Name: _____ 2) Age: ___ 3) Gender: ___ M __ F
4) Address: _____ City: _____ State: _____ Zip: _____
5) Weight: _____ 6) Height: _____ 7) Eye color: _____ 8) Hair color: _____
10) Today's date: _____ 11) Date of birth: _____ 12) Years of education: _____
13) Occupation: _____ 14) Home phone: _____ 15) Business phone: _____
16) Present marital status:

____ 1) never married
____ 2) engaged to be married
____ 3) married now for first time
____ 4) married now after first time
____ 5) separated
____ 6) divorced and not remarried
____ 7) widowed and not remarried
____ 8) other (specify) _____

17) If married, are you living with your spouse at present? ____ Yes ___ No
18) If married, years married to present spouse: _____

Counseling History

19) Are you receiving counseling services at present? ___ Yes ___ No
If Yes, please briefly describe: _____

_____

20) Have you received counseling in the past? _____ Yes ____ No
If Yes, please briefly describe: _____

_____

21) What is (are) your main reason(s) for this visit? _____

_____

_____

22) How long has this problem persisted (from #21)? _____

_____

_____

23) Under what conditions do your problems usually get worse? _____

_____

_____

24) Under what conditions are your problems usually improved? _____

_____

_____

25) How did you hear about this clinic, or who referred you? _____

_____

_____

26) Name and address of your primary physician:

Physician's name: _____

Address: _____

27) List any major illnesses and/or operations you have had: _____

_____

_____

28) List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.): _____

_____

_____

29) List any other physical concerns you are having at present: _____

_____

_____

30) When was your most recent complete physical exam? _____

Results of physical exam: _____

_____

31) On average how many hours of sleep do you get daily? _____

32) Do you have trouble falling asleep at night? ___ Yes ____ No

If Yes, describe: _____

_____

33) Have you gained/lost over ten pounds in the past year? ___ Yes ___ No

____gained _____ lost

If Yes, was the gain/loss on purpose? ____ Yes ____ No

34) Describe your appetite (during the past week):

____ poor appetite ____ average appetite ____ large appetite

35) What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

36) What is your present religious affiliation?

____ 1) Catholic

____ 2) Jewish

____ 3) Protestant (specify denomination if any) _____

____ 4) None, but I believe in God

____ 5) Atheist or agnostic

____ 6) Other (please specify) _____

37) How important is religious commitment to you?

Unimportant Average importance Extremely important

1 2 3 4 5 6 7

38) Do you desire to have your religious beliefs and values incorporated into the counseling process?

____ Yes ___ No ____ Not sure (If Yes, please explain): _____

_____

39) Mother's age: _____ If deceased, how old were you when she died? _____

40) Father's age: _____ If deceased, how old were you when he died? _____

41) If your parents separated or divorced, how old were you then? _____

42) Number of brother(s) _____ Their ages: __ ____ ____ ____ ____ ____

43) Number of sister(s) _____ Their ages: __ ____ ____ ____ ____ ____

44) I was child number _____ in a family of _____ children.

45) Were you adopted or raised with parents other than your natural parents? _Yes ___ No

46) Briefly describe your relationship with your brothers and/or sisters: _____

_____

_____

47) Which of the following best describes the family in which you grew up?

Warm and accepting Average Hostile and fighting

1 2 3 4 5 6 7 8 9

48) Which of the following best describes the way in which your family raised you?

Allowed me to be very independent Average Attempted to control me

1 2 3 4 5 6 7 8 9

Your Mother (or mother substitute)

49) Briefly describe your mother: _____

_____

_____

50) How did she discipline you? _____

_____

_____

51) How did she reward you? _____

_____

_____

52) How much time did she spend with you when you were a child?

____ much ____ average ____ little

53) Your mother's occupation when you were a child:

____ stayed home ____ worked outside part-time ____ worked outside full-time

54)How did you get along with your mother when you were a child?

____ poorly ____ average ____ well

55) How do you get along with your mother now?

____ poorly ____ average ____ well

56) Did you mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development?____ Yes ____ No

If Yes, please describe: _____

_____

57) Is there anything unusual about your relationship with your mother? ___ Yes ____ No

If Yes, please describe: _____

_____

58) Describe overall how your mother treated the following people as you were growing up:

(Circle one answer for each)

Your mother's treatment of:	Poor			Average			Excellent
1) You	1	2	3	4	5	6	7
2) Your family	1	2	3	4	5	6	7
3) Your father	1	2	3	4	5	6	7

Your Father (or father substitute)

59) Briefly describe your father: _____

_____

_____

60) How did he discipline you? _____

_____

_____

61) How did he reward you? _____

_____

_____

62) How much time did he spend with you when you were a child?

____ much ____ average ____ little

63) Your father's occupation when you were a child:

____ stayed home ____ worked outside part-time ____ worked outside full-time

64) How did you get along with your father when you were a child?

____ poorly ____ average ____ well

65) How do you get along with your father now?

____ poorly ____ average ____ well

66) Did you father have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ____ Yes ___ No

If Yes, please describe: _____

_____

67) Is there anything unusual about your relationship with your father? __ Yes ___ No

If Yes, please describe: _____

_____

68) Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

Your father's treatment of:	Poor			Average			Excellent
1) You	1	2	3	4	5	6	7
2) Your family	1	2	3	4	5	6	7
3) Your mother	1	2	3	4	5	6	7

Thoughts and Behaviors

69) Please check how often the following thoughts occur to you:

1) Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2) I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3) No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4) I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5) Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6) I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7) I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8) I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9) I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10) I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11) I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12) God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13) I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14) Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15) I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16) People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17) I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18) Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19) I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20) I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thought that occur frequently or are a concern to you. Use the back of this sheet is necessary.

_____

_____

_____

_____

_____

Symptoms

70) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

____ aggression	____ fatigue	____ sexual difficulties
____ alcohol dependence	____ hallucinations	____ sick often
____ anger	____ heart palpitations	____ sleeping problems
____ antisocial behavior	____ high blood pressure	____ speech problems
____ anxiety	____ hopelessness	____ suicidal thoughts
____ avoiding people	____ impulsivity	____ disorganized thoughts
____ chest pain	____ irritability	____ trembling
____ depression	____ judgment errors	____ withdrawing
____ disorientation	____ loneliness	____ worrying
____ distractibility	____ memory impairment	____ other (specify)
____ dizziness	____ mood shifts	_____
____ drug dependence	____ panic attacks	_____
____ eating disorder	____ phobias/fears	_____
____ elevated mood	____ recurring thoughts	_____

Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

_____

71) List some of your greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

72) List some of your greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5) _____

73)Describe some of the situations that are difficult for you: _____

74) List the behaviors you would like to change: _____

75) Additional information you believe would be helpful: _____