Adult Intake Form

Date:_____ Client Name:_____

Therapist Name:_____

What are the issues that led you to decide to come to therapy? _____

What are your goals for therapy? _____

What are your strengths and limitations? _____

What do you enjoy doing in your free time? _____

Who is a source of support for you? Any family, friends, or groups you enjoy? _____

What is your current level of stress (overall)?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○

(no stress) (high stress)

Rank in order the top three concerns that you have in your life (1 being the most problematic)

1._____

2._____

3._____

Have you received prior counseling related to any of the above concerns? ___Yes ___No

If yes, when: _____ Length of treatment: _____

What was the outcome (check one)?

___Very Successful ___Somewhat Successful ___Stayed the Same ___Somewhat worse ___Much Worse

What is your occupation? _____

Do you enjoy your job? ____Yes ____No

What was your relationship like with your family growing up? _____

Do you have children? ____Yes ____No Do they presently live with you? ____Yes ___No

Ages? _____ _____ _____ _____

Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? ____Yes ____No
If yes, please describe: _____

Has there been any verbal, emotional, physical, or sexual abuse that has happened to you?
____Yes ____No
If yes, was the assailant someone you knew? ____Yes ____No
When did this happen? _____
Where is this person now? _____

Have you ever had any legal issues? ____Yes _____No
If yes, please describe: _____

Are you currently experiencing any suicidal thoughts? ____Yes ____No
Have you had a suicidal attempt? ____Yes ____No
If yes, date of last attempt and treatment:

Has anyone in your family ever been treated for psychiatric reasons? ____Yes ____No
If yes, please describe:

Does anyone in your family have any know mental health diagnoses? ____Yes ____No
If yes, please describe who and their diagnosis: _____

Do you have any mental health diagnoses? ___ Yes ___ No
If yes, please describe:

Do you have a medical provider? ____Yes ____No
If yes, what is his or her name? _____

Do you have any medical issues? ____Yes ____No
If yes, please describe:

Please list any medications you are currently taking, or have taken during the past 6 months. (Include prescribed and over the counter medications)

Medication	Dosage	Used for	Prescribing Doctor

Check any of the following symptoms or concerns that you are currently or have recently experienced:

____ Stress
____ Chronic Pain
____ Loneliness
____ Fatigue
____ Relational issues
____ Low self-esteem
____ Compulsive behavior
____ Grief
____ Sexual addiction
____ Poor Concentration
____ Aggression
____ Eating problems
____ Controlling
____ Obsessive thoughts
____ Hearing voices
____ Racing thoughts
____ Loss of control
____ Drug/Alcohol use
____ Impulsive behaviors
____ Sexual concerns
____ Depression
____ Gender identity
____ Trouble sleeping
____ Unwanted memories
____ Pregnancy/Abortion
____ Anxiety
____ Fears
____ Panic
____ Anger
____ Bad dreams

Please share information about substance use by **you or other people** who are significant in your life.

Substance	Who? Self or Other (identify relationship)	How much and how often	When last used?	Age started using
Caffeine				
Tobacco				
Alcohol				
Marijuana/Pot				
Cocaine/Crack				
Opiates/Narcotics (i.e. pain killers)				
Barbiturates/Sedatives/Tranquilizers				
Amphetamines/Stimulants				
Hallucinogens/LSD/Psychedelics				
Other:				

Any other information you think is important for me to know?