Creating Hope Counseling
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ADULT'S INTAKE INFORMATION

Name:_____ Date:_____

Address:_____
Street City State Zip Code

Phone: Home_____ Work_____ Cell_____
May we call you at home? Yes_____ No _____ May we call you at work? Yes_____ No_____

DOB:_____ Age:_____ SS#_____ Email: _____

Credit Card # _____ Expiration Date_____ Security #_____

Sex: M / F Education (circle one) H.S. A.A. B.A. M.A. PhD

FAMILY INFORMATION AS AN ADULT

Spouse/Partner _____Status: __Married __ Separated __Divorced __Other

Names and ages of Children:

_____ _____
_____ _____

Employer: _____ Occupation_____
Address_____

Spouse's or partner's name (if applicable) _____
Occupation_____ Employer and Address_____

MEDICAL HISTORY

Insurance_____ Plan # _____
Physician_____ Phone #_____

Current health Problems_____

Medications *(include dosage and frequency)*_____
Medication Allergies: _____ Other Allergies: _____

As a minor did you experience: __Separation from mother __Out of Home Care __Abuse __Disruption in bonding __Depression of mother __Neglect __Parental Stress
If yes, please specify: _____

As an adult have you experienced: __Separation from spouse/partner __Chronic Pain __Depression of Spouse/Partner/children __Abuse __Neglect __Marital Stress __Work/school related stress __Family stress
If yes, please specify: _____

FAMILY INFORMATION AS A MINOR

Bio/Step/Foster/Other Dad_____*DOB*_____
Your relationship with this parent: ___In contact: pleasant, conflicted __No contact __Disappeared __ Deceased
Bio/Step/Foster/Other Mom _____*DOB* _____
Your relationship with this parent ___ In contact: pleasant, conflicted __ No contact __Disappeared __ Deceased

Their relationship status: __Never Married __Married __ Separated __ Divorced

How would you describe your family of origin and your experiences while growing up?
_____
_____
_____

Bio/Step/Foster Siblings (Oldest to Youngest)
_____ **DOB__/__/__ Relationship:** *In contact: pleasant, conflicted __ No contact*
_____ **DOB__/__/__ Relationship:** *In contact: pleasant, conflicted __ No contact*
_____ **DOB__/__/__ Relationship:** *In contact: pleasant, conflicted __ No contact*

Family History as a Minor

If your parents separated or divorced while you were a minor, visitation schedule_____
History of mental illness or addiction in immediate or extended family *(ex. Depression, Anxiety, manic-depressive, suicide attempts, alcoholism, drugs, ADHD, etc.).* **while you were a a minor:**_____
Did you witness parental arguments as a minor? __ Yes __No, Specify _____
Did you witness domestic violence as a minor? __ Yes __ No, Specify_____
How were you disciplined? _____ **Method Frequency** _____

TRAUMA HISTORY

Have you been verbally abused or verbally abused someone else? __Yes __No
Have you been physically abused or physically abused someone else? __Yes __No
Have you been sexually abused or sexually abused someone else? __Yes __No
Other stressors or traumas? _____

Do you or your family attend church/temple? _____

Have you gone to a counselor before? _____ Positive Experience?_____
Name_____ Phone #_____
Issues worked on_____
What do you hope to gain through counseling?
Referred by _____

What have your already done to deal with the difficulties?_____
_____

What are your biggest strengths? What do you do for fun/to relax? _____
_____
_____
_____
_____

Please circle the behaviors and symptoms that occur to you more often than you would like:

Aggression/fighting	Dizziness	Irritability	Sleeping problems
Alcohol Abuse	Drug Abuse	Judgment errors	Speech Problems
Angry outbursts	Eating Disorders	Loneliness	Suicidal thoughts or actions
Arguments/conflicts	Elevated Mood	Memory Impairment	Thoughts disorganized
Anxiety	Fatigue	Mood swings	Trembling
Avoiding People	Frequent illness	Panic attacks	High blood pressure
Chest Pains	Gambling	Phobias/fears	Withdrawing
Computer addiction	Hallucinations	Recurring thoughts	Worrying
Depression	Heart palpitations	Sexual addiction	Stomachaches, headaches, etc
Disorientation	Hopelessness	Sexual difficulties	Other:
Distractibility	Impulsivity		

Briefly describe how the above-circled symptoms impair your ability to function effectively: _____
_____

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else: ___Yes ___No. If Yes please describe the situation: _____
_____
_____

Have you ever purposely hurt yourself or someone else? ___Yes ___No. If Yes please describe the situation: _____
_____

Is there anything happening NOW in your current living situation or in your family that is especially stressful to you? _____
_____

Substance Use (if present or past substance abuse, please indicate frequency)					
	None	Present	Frequency	Past	Frequency
Alcohol	☐	☐		☐	
Tobacco	☐	☐		☐	
Caffeine	☐	☐		☐	
Non-Prescription Drugs	☐	☐		☐	
Prescription Drugs	☐	☐		☐	
Marijuana	☐	☐		☐	
Cocaine/crack	☐	☐		☐	
Heroin/opiates	☐	☐		☐	
Meth Amphetamines	☐	☐		☐	
PCP/LSD	☐	☐		☐	
Inhalants	☐	☐		☐	
Other:	☐	☐		☐	
Have any substances created a problem for you at home, work or school? ☐ No ☐ Yes ☐ Not applicable					
If yes, indicate type of problems:					