

Creating Hope Counseling
Sharon L. Richards, License # LF60032243

201 NE Park Plaza Dr. #200
Vancouver, WA 98684
(360)-977-8116

1438 B Street
Washougal, WA 98671
(360)-977-8116

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 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 you 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: _____