Adult Counseling Intake Form

Name:	DoB:	Age:

Sex: ☐ Male ☐ Female ☐ Non-Binary

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Cohabitating ☐ Divorce in process
☐ Separated ☐ Widowed

Length of current marriage/relationship: .....

How many times have you been married? .....

Rate your current relationship, if applicable: ☐ Poor ☐ Fair ☐ Good

Educational Status

Years of education completed: .....

Currently enrolled in High School/GED?	☐ Yes	☐ No
College?	☐ Yes	☐ No
Vocational?	☐ Yes	☐ No
Graduate School?	☐ Yes	☐ No
Other training?	☐ Yes	☐ No

If yes, what training? .....

Any Special Circumstances regarding education? .....

Military Experience (if any)

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Where? ..... Branch: .....

Length of service: ..... Type of Discharge: .....

Rank at discharge: .....

Career

Current employment/job title: .....

Employment history: .....

.....

Level of job satisfaction (1-5): ..... Why? .....

Gaps in employment history (if any): .....

Reasons for leaving your work (if applicable): .....

Personal Strengths

What activities do you enjoy and feel you are successful when you try?

Name:	DoB:

What personal qualities do you think you have?

What personal qualities would others say you have?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? Be as descriptive as you can.

Traumas or Significant Losses

Have you experienced any traumatic events or significant losses? If so, tick what you think applies to you and indicate anything that's not included in the list:

- ☐ Abduction
- ☐ Bullying
- ☐ Chronic Illness
- ☐ Cultural
- ☐ Criminal
- ☐ Deaths
- ☐ Divorce / Separation
- ☐ Emotional
- ☐ Financial
- ☐ Hate crime
- ☐ Identity theft
- ☐ Internet Fraud
- ☐ Isolation
- ☐ Loss of Culture
- ☐ Loss of Independence
- ☐ Medical / Physical
- ☐ Sexual Abuse
- ☐ Stalking
- ☐ Torture / War
- ☐ Witness of Trauma
- ☐ Work Related/Job Loss

Family History

What words would you use to describe your family?

Are you aware of any birth trauma your mom had during her pregnancy with you, or from age 0-3? Yes or No? If yes, what did she think of it?

Name:	DoB:

Did you experience any abuse as a child, whether at home or outside (physical, verbal, emotional, or sexual)? Please describe as much as you feel comfortable.

Do you experience abuse in your adult life? Please describe as much as you feel comfortable.

Did you get the support that you needed from your family or friends?

Counseling/Medical History

Have you previously seen a counselor? ☐ Yes ☐ No

If yes, where? .....

Approximate Dates of Counseling: .....

For what reason did you go to counseling? .....

Do you have a previous mental health diagnosis? .....

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Have you used psychiatric services? ☐ Yes ☐ No

If yes, who did you see? .....

If yes, was it helpful? ☐ Yes ☐ No ☐ N/A

Have you taken medication for a mental health concern? ☐ Yes ☐ No

If yes, what medication and dosage?

Name:	DoB:

History of Substance Abuse

Do you currently use alcohol? ☐ Yes ☐ No

If yes, how often do you drink? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

If yes, how much do you drink? .....

Do you currently use Tobacco? ☐ Yes ☐ No

If yes, how much do you smoke/chew? .....

Do you currently use any drugs (legal or illegal)? ☐ Yes ☐ No

If yes, what drugs do you use? .....

If yes, how often do you use drugs? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Have you received any previous treatment for chemical use? ☐ Yes ☐ No

If so, where did you go? .....

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have you ever had people annoy you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started? ☐ Yes ☐ No

Legal Issues

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

How did these issues affect you and your loved ones, or how are they affecting you now?

Emotional/Mental Health

How would you describe yourself when it comes to your emotions?

Have you ever had thoughts about self-harm or harming others?

Name:	DoB:

Have you enacted those thoughts? If so, why?

Would you happen to have a support system? If so, who comprises this system?

Have you ever experienced hospitalization/treatment for psychiatric problems?

Would you happen to have any memory and cognitive problems?

What significant problems or stresses are you facing at the present time?

Spirituality/Beliefs

Is there any specific belief system that we counselors/therapists need to be aware of?

Did religion/spiritual practice play a part in your upbringing?

Name:	DoB:

Reasons for Seeking Counseling

Briefly describe the problem for which you are seeking to have counseling/therapy for?

When do you think these problems/symptoms first occurred?

What is most concerning for you right now?

What is most concerning for your family and friends regarding you right now that you are aware of?

What would you like to see happen as a result of counseling/therapy?

Anything else you'd like to share?

Confidentiality: We employees of ..... adhere to a strict standard of confidentiality. All the information that you shared in this intake form will be protected by the counselor/therapist who will be assigned to you and so will our staff members. Nothing that you've shared with us through this form will be shared or disclosed to anyone else without your permission, save for certain reasons like legal or medical reasons. Please read our Notice of Privacy Practices to know more about your rights and what rules we have to follow in relation to your health information.

I, ... , understand the above and have thoroughly read the Notice of Privacy Practices.

	Signature:
Witness Name:	**Witness Signature:**