

# Please fill out each section on this form.

If a section does not apply, please write N/A over that section.

Thank you.

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## ADULT INTAKE ASSESSMENT FORM

Please answer all of the following questions to the best of your ability.

### IDENTIFYING INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_  
 Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell/other phone: \_\_\_\_\_

Is it OK to contact you at home?  Yes  No OK to leave a message?  Yes  No

Special calling instructions? \_\_\_\_\_

Business phone: \_\_\_\_\_

Is it OK to contact you at work?  Yes  No OK to leave a message?  Yes  No

Special calling instructions? \_\_\_\_\_

How did you learn about my services? \_\_\_\_\_

### OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply:  employed  retired  disabled  student  homemaker  unemployed  
If/When employed, what type of work do you do? \_\_\_\_\_

Current employer: \_\_\_\_\_ Years on Current Job: \_\_\_\_\_

Are you currently having difficulties on the job because of (Check if yes):

- emotional problems?
- substance abuse?

Have you ever had difficulties at work because of (Check if yes):

- emotional problems?
- substance abuse?

If yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Ever in Military Service:  yes  no

Currently in military?  yes  no Branch: \_\_\_\_\_

If you served in combat, when did you serve? \_\_\_\_\_

Type of discharge: \_\_\_\_\_

Reason for discharge: \_\_\_\_\_

### MARITAL STATUS

Marital/relationship status (Check one):  Married;  Live with partner (check if same \_\_\_ or opposite\_\_\_ sex);  Single;  Separated/Divorced;  Widowed; or  Other: \_\_\_\_\_

**MARITAL STATUS (continued)**

If previously married, please provide dates of Marriage(s): \_\_\_\_\_

Number of years currently married: \_\_\_\_\_

Are you experiencing any problems/stresses in your current marriage/relationship?  yes  no

Did you experience any problems/stresses in your previous marriage/relationship?  yes  no

Comments regarding stresses in current or previous marriage(s)/relationship(s): \_\_\_\_\_

\_\_\_\_\_

If you have had problems in the past, what do you think caused those relationships to end? \_\_\_\_\_

\_\_\_\_\_

**EDUCATION**

Last grade completed in school/college is/was: \_\_\_\_\_ Degree: \_\_\_\_\_

Are you currently enrolled in school?  yes  no Major/focus: \_\_\_\_\_

Do you have any special training, skills, or certification? (list): \_\_\_\_\_

\_\_\_\_\_

Do you have any problems reading or writing?  yes  no

Do you have any difficulty understanding (check any that apply):  spoken instructions  
 written instructions  
 demonstrated instructions

How do you learn best? \_\_\_\_\_

What was school like for you? \_\_\_\_\_

Describe any difficulties or problems you had/have in school: \_\_\_\_\_

\_\_\_\_\_

**REASON FOR SEEKING**

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly. \_\_\_\_\_

\_\_\_\_\_

What has happened to cause you to seek help NOW? \_\_\_\_\_

\_\_\_\_\_

What do you hope to be able to do or achieve as a result of treatment? \_\_\_\_\_

\_\_\_\_\_

What do you consider to be the other stresses in your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORY OF THE PROBLEM**

When did you first start experiencing the problem(s) that bring you to the clinic today?

\_\_\_\_\_

How often does the problem occur? \_\_\_\_\_

How long does it last? \_\_\_\_\_

Do you currently have thoughts of harming yourself?  yes  no

Do you currently have thoughts of wishing you were dead?  yes  no

Do you currently have urges to hurt, harm, or kill someone else?  yes  no

If yes, whom? \_\_\_\_\_

Have you ever seriously considered suicide or felt like harming someone else?  yes  no

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any problem with any of the following:  overspending  food binging

intentional vomiting  yelling/threatening  risk taking/ endangering self or others

hitting, shoving, choking, or hurting others  throwing or breaking things

stealing  internet overuse or misuse  sexual feelings/behaviors

Have you ever had previous therapy/counseling of any kind?  yes  no

If yes, when and for how long? \_\_\_\_\_

What concerns did you address in previous therapy? \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for emotional problems?  yes  no

Have you ever been hospitalized for substance abuse problems?  yes  no

If yes to either of the above, when, where, and for how long were you hospitalized? \_\_\_\_\_

\_\_\_\_\_

Were any of your previous treatment experiences helpful?  yes  no

Please explain how you benefited or did not benefit from previous treatment: \_\_\_\_\_

\_\_\_\_\_

What medication(s), if any, have you found helpful in managing your emotional problems? \_\_\_\_\_

\_\_\_\_\_

Have you had any experience with self-help support groups?  yes  no

If yes, please explain when, which ones, and whether or not you found them helpful:

\_\_\_\_\_

\_\_\_\_\_

**SUBSTANCE USE HISTORY**

Have you ever experienced a problem with alcohol, drugs, or prescription medications?  yes  no

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SUBSTANCE USE HISTORY (continued)**

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications?

yes  no If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs?  yes  no

If, yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had any problems related to use of alcohol/drugs in the past year?  yes  no

If, yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Has drinking or drug use ever caused you problems in the following areas (check if yes):

family  school  employment  legal  emotional  social  financial  behavior  
 physical health  other, please describe: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY BACKGROUND**

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN

Names of children	Living with you?	Age	Grade	School
1. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
2. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
3. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
4. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
5. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____

Other than any children already indicated above, who lives in your household?

\_\_\_\_\_  
\_\_\_\_\_

Please describe your relationships with other family members:

Relationship	Living?	Frequency of contact?	Describe quality of relationship
Father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Step-father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Step-mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Spouse/partner	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Sister(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Brother(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Other	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____

Whom were you raised by? \_\_\_\_\_ Were you adopted?  yes  no

Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY BACKGROUND (continued)**

What family member(s) are you closest to now? \_\_\_\_\_  
\_\_\_\_\_

As you were growing up, what adult(s) stood out as people you could really trust? \_\_\_\_\_  
\_\_\_\_\_

Check the statement(s) below that describe the type of family you grew up in:

- overly close family     no "breathing room"     everyone was in everyone else's business
- no privacy     boundaries not respected     Comfortably close family     loving
- shared many positive experiences     supportive     distant, everyone did their own thing
- not much time spent together     not a lot of support     angry, lots of fighting/hostility
- verbal abuse and conflicts     violence     frightening     scared to make mistakes
- other descriptors: \_\_\_\_\_

Have any biological relatives ever had any emotional problems or substance abuse?  yes  no  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family ever attempted or committed suicide?  yes  no  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**RACE/ETHNICITY**

	Self	Spouse
European-American	_____	_____
African-American	_____	_____
Hispanic-American	_____	_____
Native-American	_____	_____
Asian-American	_____	_____
Other _____	_____	_____

**RELIGIOUS AFFILIATION**

	Self	Spouse
Catholic	_____	_____
Jewish	_____	_____
Muslim	_____	_____
Protestant	_____	_____
Non-Denominational	_____	_____
Eastern (e.g., Hindu, Buddhist)	_____	_____
Other _____	_____	_____

**HEALTH/MEDICAL INFORMATION**

Physician	Address & Telephone #	Approx Date of last visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: \_\_\_\_\_  
\_\_\_\_\_

Do any of these problems affect your everyday life?  yes  no    If yes, how so? \_\_\_\_\_  
\_\_\_\_\_

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): \_\_\_\_\_  
\_\_\_\_\_

**HEALTH/MEDICAL INFORMATION (continued)**

Have you ever had a serious head injury?  yes  no If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications?  yes  no If yes, which one(s): \_\_\_\_\_

\_\_\_\_\_

**List all medications that you currently use:**

Medication(s)	Dosage (amount and times per day)	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any "alternative" therapies/treatments you are currently using and the reason for each:

\_\_\_\_\_

\_\_\_\_\_

**Have you ever had or do you now have a problem with any of the following? (Check all that apply):**

General

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Recent Fever/Chills               | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Cigarette Smoking  |
| <input type="checkbox"/> Chronic Fatigue                   | <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Other Tobacco Use  |
| <input type="checkbox"/> Frequent or Terrifying Nightmares | <input type="checkbox"/> Drug Reaction                     | <input type="checkbox"/> Alcohol Use        |
| <input type="checkbox"/> Night Sweats                      | <input type="checkbox"/> Emotional Problems                | <input type="checkbox"/> Drug Use           |
| <input type="checkbox"/> Insomnia or Sleep Problems        | <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Suicide Attempt(s) |
| <input type="checkbox"/> Chronic Pain _____                | <input type="checkbox"/> Exposure to Trauma (Type: _____ ) |   |

Gastrointestinal/Hepatic/Endocrine

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Weight Loss/Gain   |
| <input type="checkbox"/> Gastritis           | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Vomiting Blood      | <input type="checkbox"/> Colitis         | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Pancreatitis        | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Always Thirsty     |
| <input type="checkbox"/> Gall Bladder/Stones | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Swollen Glands     |
| <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Liver Problems  | <input type="checkbox"/> Low Blood Sugar    |
| <input type="checkbox"/> Gallbladder/Stones  | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Swollen Glands     |
| <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Liver Problems  | <input type="checkbox"/> Low Blood Sugar    |

Musculoskeletal

- Broken Bones
- Bad Back
- Herniated Disk
- Muscle Weakness
- Joint Pain H
- Arthritis
- Gout

Cardiovascular

- Angina
- Fainting
- Lightheadedness
- Irregular Heart Beat
- High/Low Blood Pressure
- Rheumatic Fever
- Heart Valve Problems

Pulmonary

- Chest Pains/Pressure
- Shortness of Breath
- Cough
- Wheezing/Asthma
- Coughing Blood
- Tuberculosis
- Pneumonia

**HEALTH/MEDICAL INFORMATION (continued)**

Neurological

- Headaches
- Migraines
- Skull Fracture
- Epilepsy
- Stroke
- Paralysis
- History of Head Injury
- Double Vision
- Memory Loss
- Unsteady Gait

Urinary/Genital

- Frequent Urination
- Burning on Urination
- Weak Urinary System
- Incontinence
- Urinary Tract Infection
- Blood in Urine
- Kidney Infection
- Penis/Vaginal Discharge
- Menstrual Difficulties
- Sexual Difficulties
- STD

Skin/Sensory Systems

- Sores/Abscesses
- Skin Rash
- Eye Trouble
- Hearing Loss
- Ringing in Ears
- Perforated Septum
- Nose Bleeds
- Gum Bleeding
- Mouth Sores
- Difficulty Swallowing

**INTERESTS AND ACTIVITIES**

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: \_\_\_\_\_

\_\_\_\_\_

Please describe your personal strengths and positive characteristics: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information you feel is important and wasn't asked about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IN CASE OF EMERGENCY**

Name(s)

Relationship to Client

Telephone No.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thank you for your time and cooperation.**

**Staci Rocha MA LPC**