Client Information: Adult Intake

The following information will be kept strictly confidential.

Name (First, Middle Initial, Last):	**Today's Date:**
Date of Birth:	**Insured Name:**
Age:	**Insured SSN:**
Gender:	**Employer of Insured:**
SSN:	**Relationship to Insured:**
Home Address (Street, City, State, Zip):	**Mailing Address** (if different):
Daytime Phone:	**Home Phone:**
Cell Phone:	**Email Address:**

Current Relationship Status: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity (This data is required for legal purposes): ☐ African-American/Black ☐ Asian ☐ Hispanic ☐ Caucasian/White ☐ Hawaiian/Pacific Islander ☐ Native American ☐ Other _____

If you typically live at home: *People living at home* with you (Please include **all individuals**):

Name	Age	Relationship to you (for example spouse, significant other, son/daughter)	Occupation or grade

If you *do not* live in a home/apartment, please *indicate your type of residency* (Such as group home, nursing facility, other official type of residence, college dormitory, homeless):_____

Legal Guardianship: I am my own legal guardian ☐ Yes ☐ No.

If no, who is legal guardian? _____

Primary Care Provider: _____

Name Practice Address Phone

When did you last see your Primary Care Provider? _____

Who referred you to Albemarle Counseling Group?

_____

Why are you coming to see a therapist and what happened to make you seek help now?

_____

_____

Problems: Please check any problems that you have currently or that have bothered you in the past.

	Now	Past		Now	Past
Problems sleeping	☐	☐	Less hungry/weight loss	☐	☐
Problems concentrating	☐	☐	Increased hunger/weight gain	☐	☐
Crying spells	☐	☐	Feeling hopeless/helpless	☐	☐
Depression/Sadness	☐	☐	Anxiety/Worry	☐	☐
Thoughts of suicide	☐	☐	Thoughts of hurting others	☐	☐
Relationship problems	☐	☐	Legal problems	☐	☐
Problems with alcohol	☐	☐	Problems with drugs	☐	☐
Job problems	☐	☐	Problems with the past	☐	☐
Disturbing thoughts	☐	☐	ADHD	☐	☐

Please list any other ***emotional/behavioral problems*** that you may have: _____

_____

_____

Please list any ***significant medical problems*** that you have now: _____

_____

_____

Please list any ***known drug allergies***; if none, please write "None". _____

Please list any ***prescription medications*** that you are taking now. Use other pages as necessary:

Medication	Dosage	Prescribed for treatment of:	Prescribing Physician	Does it Help?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Please list all ***significant medical treatments*** you have had (include surgeries, medical therapies, and hospitalizations). Use other pages as necessary:

Type of Treatment	Treatment for what Disorder	Year of Treatment	Did/does it help?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Please list all ***behavioral health or psychotherapeutic treatments*** you have had to include hospitalizations, medication management, and outpatient psychotherapy. Use other pages as necessary.:

Type of Treatment (i.e. inpatient, outpatient, med management)	Treatment for What Disorder	Provider	Date/Year	Did/does it Help?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Family of Origin History:

Who primarily raised you and what was his/her/ their relationship to you?

_____

Are you still in contact with who raised you? _____

Birth Mother's Name: _____ Mother's age (if alive): _____

If deceased, when did she die? _____ What type of work does/did she do?_____

Birth Father's Name:_____ Father's age (if alive): _____

If deceased, when did he die? _____ What type of work does/did he do? _____

Were your parents/guardians married? ☐Yes ☐No Did they stay married? ☐Yes ☐No

If they divorced, how old were you? _____ Did either of your parents/guardians remarry? ☐Yes ☐No

Please *list names of stepparent(s) and surrogate parents*, their relationship to you, and indicate if the relationship was positive for you:_____

_____

Siblings: *Include half & step siblings if they were important to you. Indicate relationship—full, half, step.*

Brothers: _____ Please list names and ages of brothers: _____

_____

Sisters: _____Please list names and ages of sisters: _____

_____

Have any members of your family suffered from mental, emotional, or nervous problems? ☐ Yes ☐No

If yes, please describe who and type of problem:_____

Have any members of your family suffered from problems with drugs or alcohol abuse? ☐ Yes ☐No
If yes, please describe who and type of problem:_____

Childhood History:
As far as you know, did your mother have any problems with her pregnancy and/or delivery of you?
☐ Yes ☐No If yes, what? _____
As a child, did you have problems learning to walk, talk, toilet train, etc.?
☐ Yes ☐No If yes, what? _____
As a child, did you experience any major illness, losses, or separations?
☐ Yes ☐No If yes, what? _____
As a child, were your parents/guardians supportive of you? Did you feel loved? ☐ Yes ☐No
Comments: _____
Were you ever abused, molested, or neglected as a child? ☐Yes ☐No
If yes, please describe:_____
As a child, did you suffer any trauma or significant losses? ☐Yes ☐No If yes, please describe and indicate if you are still bothered by the event(s): _____
_____
Did you fit in as a child? ☐Yes ☐No Comments: _____

Social/Interpersonal/Current Life Situation:
Are you happy with your current social and personal life? ☐Yes ☐No Comments: _____
_____
If you have dated, when did you first begin to date? _____
Have you ever married? ☐Yes ☐No If yes, please list dates for each marriage and, if applicable, dates for each divorce: _____
_____
Are you currently married? ☐Yes ☐No If yes, name and age of spouse:_____
If married, how would you categorize the marriage (Happy, unhappy, stable, etc.)? _____
_____
Please list *any children you have or have raised* for extended periods:

Name	Relationship: Son, daughter, stepchild, adopted, foster,	Age / Grade	Sex	If still a minor, who does this child life with.	If this individual doesn't live with you, are you still in contact?

Adult Trauma: As an adult, have you suffered any trauma/abuse/assault/or significant losses?
☐Yes ☐No If yes, what was (were) the event(s) and when did it/they take place? _____
_____
If yes, are you still bothered by the event(s)? ☐Yes ☐No

Education:
Did you graduate from high school? ☐Yes ☐No If no, last grade completed: _____
If yes, please indicate if you received a diploma or a certificate of attendance. ☐ Diploma ☐Certificate
If no, do you have a GED? ☐Yes ☐No A high school equivalency diploma? ☐Yes ☐No
Did you attend college or vocational training? ☐Yes ☐No If yes, for how long?_____
List all degrees and major areas of study: _____
What kind of academic marks did you get in grade and high school? _____
Did you have any problems with learning? If yes, what?_____
Were you ever in Special Education/Exceptional Children Services? ☐Yes ☐No
Were you ever told you had a Learning Disability? ☐Yes ☐No
Did you repeat any grades in school? ☐Yes ☐No
Did you have any behavioral problems in school? ☐Yes ☐No
If yes, what were they? _____

Employment:
What type of work do you do? _____
Are you working within your chosen career field? ☐Yes ☐No
How long have you been in your current job? _____
How many/what kind of jobs have you had in the past ten years? _____
If employed, are you satisfied in your current job? ☐Yes ☐No If no, why? _____
Have you ever been fired from a job? ☐Yes ☐No If yes, why? _____
Have you ever been disabled from work? ☐Yes ☐No If yes, why? _____
Have you ever gotten into trouble at work because of your temper, violence, alcohol, or substance abuse?
☐Yes ☐No If yes, please describe: _____

Legal History:
Have you ever been arrested? ☐Yes ☐No
If yes, what were the charges? _____
Have you ever been convicted of a crime other than a minor traffic violation? ☐Yes ☐No
If yes, what crime(s) were you convicted of? _____
Have your ever served time in a jail or prison or was placed on probation? ☐Yes ☐No
If yes, describe. Please note number of incarcerations and for how long: _____
_____

Substance Use/Abuse:
Do you smoke cigarettes? ☐Yes ☐No If yes, habit per day? _____
How much caffeine do you drink per day? _____
On average, how much alcohol do you drink daily? _____
How often do you get "tipsy"? _____ How often do you get drunk? _____
Have you...
Decided to cut down on your drinking? ..... ☐Yes ☐No
Ever been annoyed by questions about your drinking? ..... ☐Yes ☐No
Felt guilty about your drinking? ..... ☐Yes ☐No
Needed a morning eye opener? ..... ☐Yes ☐No
Do *you* believe that you have a problem with drinking? ..... ☐Yes ☐No ☐Maybe
Please list any drugs that have been a problem for you *in the past*: _____
_____
_____
Do *you* believe that you have a problem with drugs? ☐Yes ☐No ☐Maybe
Please list any non-prescription recreational drugs that you *currently use*. Note quantity and frequency:
_____
_____

Social and Emotional Support:
Do you have people in your life that you can talk to? ☐Yes ☐No
Do you have people in your life that are supportive of you? ☐Yes ☐No
If yes, who is/are your major support(s):_____
Are you involved in organized religion? ☐Yes ☐No If yes, faith: _____
Is your faith important to you? ☐Yes ☐No
What do you do for fun? Any Hobbies? _____
_____

Goals:
What changes do you hope to achieve by coming to Albemarle Counseling Group? What else would you like your therapist to know?
_____
_____

Signature of Person Completing this form: _____