**CYNDIE FORD PURDY, LMHC**

**ADULT INTAKE INVENTORY**

Name:_____ Date:_____

Date of birth:_____Place of birth:_____ How long in FL?_____

SS #:_____ Referred by:_____

Address:_____

City, State, Zip:_____How long here?_____

Cell phone: _____ Work phone: _____ Home phone:_____

E-mail:_____ Best way to contact you:_____

May we contact you by e-mail? ☐Yes ☐No

## PERSONAL INFORMATION

Gender: ☐Female ☐Male Race: _____

Sexual orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Prefer not to answer

Education completed: ☐High school/GED ☐Community college ☐College ☐Graduate school
Other (e.g., trade school, certifications):_____

Plans for continuing education? ☐Yes ☐No ☐Uncertain ☐Would like to

If yes, what would you like to study?_____

Employed? ☐Yes ☐No Employer_____

Occupation:_____ How long?_____

Religious preference:_____ Regular church attendance? ☐Yes ☐No

What hobbies, leisure or recreational activities do you enjoy?_____

_____

How often do you participate in hobbies, leisure or recreational activities?_____

Military service and discharge information:_____

Are you on disability? ☐Yes ☐No Are you applying for disability? ☐Yes ☐No

## RELATIONSHIPS

Please mark the answer that best describes your childhood:

☐Very happy ☐Happy ☐Average ☐Unhappy ☐Very unhappy

Who raised you (check all that apply)?

☐Biological parents ☐Parent and step-parent ☐Single parent (mother) ☐Single parent (father)

☐Adoptive parents ☐Foster parents ☐Relatives ☐Unrelated friend(s) of family

How many siblings do you have?_____ What birth order are you?_____

Marital status: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Cohabitate ☐Single

How long married?_____ #Children from this marriage:_____

Spouse's name:_____ Is your spouse living with you? ☐Yes ☐No

Spouse's occupation:_____ How long?_____

If not married, which best describes your relationship status:

☐Live-in companion ☐Dating ☐Engaged to be married ☐No involvement

Are you happy with your relationship status? ☐Yes ☐No ☐Prefer not to answer

# Previous marriages:_____ # Previous live-in companions:_____

# Full-term pregnancies:_____ #Abortions:_____ #Miscarriages:_____

List all your children below (include biological children, stepchildren, adopted children, foster children):

| Name | Age | Relationship to you | Does this child live with you now? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Who else lives with you? _____

_____

Are you being physically, sexually, verbally, or emotionally abused? ☐Yes ☐No

If yes, who is hurting you?_____

Do you have a safety plan? ☐Yes ☐No Would you like to develop one? ☐Yes ☐No

## HEALTH INFORMATION

**LIST ALL YOUR MEDICATIONS ON THE SEPARATE FORM PROVIDED.**

Who is your primary physician?_____

When was your last medical examination?_____

What was the purpose of your last visit?_____

Please list any allergies you have, including any allergies or allergic reactions to medications:

_____

Current health status: ☐Excellent ☐Very good ☐Good ☐Average ☐Poor

Are you now or could you be pregnant? ☐Yes ☐No

Please list present symptoms and/or medical conditions:_____

_____

Are you being treated for these problems? ☐Yes ☐No

If yes, who is treating you?_____

Ever have a head injury or trauma? ☐Yes ☐No If yes, when?_____

Knocked unconscious? ☐Yes ☐No If yes, when?_____

If you sustained a head injury, were you treated? ☐ Yes ☐ No

Please list surgeries, medical procedures, or treatments_____

_____

_____

Do you have any learning disabilities or handicaps? ☐Yes ☐No

If yes, please describe:_____

## SUBSTANCE USE

Do you smoke cigarettes? ☐Yes ☐No ☐Previously

If yes, when did you start?_____ How much do you smoke?_____

Have you ever tried to quit? ☐Yes ☐No If yes, when was last attempt?_____

If you previously smoked, how long has it been since you quit?_____

Do you consume alcoholic beverages? ☐Yes ☐No

Age of first use:_____ Age of regular use:_____ Age of heaviest use:_____

Do you drink every day? ☐Yes ☐No If yes, how much?_____

If no, do you drink every week? ☐Yes ☐No If yes, how much?_____

When did you last consume alcoholic beverages?_____ How much?_____

Do you wake up sweaty, shaky, feeling sick and/or needing a drink? ☐Yes ☐No

Do you have hangovers? ☐Yes ☐No Ever experienced a blackout? ☐Yes ☐No

What is the most you drink when consuming alcohol?_____

What is the average/typical amount you drink when you use alcohol?_____

Does anyone complain about your drinking? ☐Yes ☐No If yes, who?_____

Do you worry about your drinking? ☐Yes ☐No

Have you tried to stop? ☐Yes ☐No If yes, when was last attempt?_____

Do you use any other substance (i.e., cannabis, pain pills, meth, cocaine)? ☐Yes ☐No

If yes, please answer the following as accurately as possible (use back if needed):

| Substance | When was last use? | Age at first use? | How much do you use each time? | How do you use this substance? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you ever been admitted to detox for any substance? ☐Yes ☐No

If yes, when?_____ What substance?_____

Did your mother drink or drug during any of her pregnancies? ☐Yes ☐No ☐Don't know

If yes, how do you know?_____

Did your parents or caretakers misuse alcohol or other drugs? ☐Yes ☐No

Was there physical, sexual or emotional abuse in your childhood home? ☐Yes ☐No

If yes, please describe:_____

If you are pregnant, are you currently drinking or using other drugs? ☐Yes ☐No

If yes, what substances are you using?_____

How much are you using?_____ How often are you using?_____

Have you spoken to your doctor about your use? ☐Yes ☐No

## LEGAL HISTORY

List any current or past legal problems, including those associated with alcohol or other drugs:

_____

_____

## COUNSELING

List previous counseling, psychotherapy, psychiatric or substance abuse treatment below:

_____

_____

Are you currently being treated by a psychiatrist? ☐Yes ☐No

If yes, who is your psychiatrist?_____

Have you ever been admitted to a psychiatric or mental health unit? ☐Yes ☐No

If yes, please provide information below:

| Date of Admission | Date of Discharge | Reason for Admission | Voluntary, Yes or No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What problems would you like to discuss?

_____

_____

_____

What improvements do you want to make in your life circumstance?

_____

_____

_____

In case of emergency, whom would you like us to notify?_____

Address:_____

Phone #:_____

Relationship to client:_____

**(Please note, we may ask you to sign an Authorization for this person)**