Asheville Counseling and Training Services, Inc.
A North Carolina Professional Corporation

Intake Form for Adults: CONFIDENTIAL

Client's name: _____Date of birth: _____ Age: _____

Driver's License State/Number: _____ SS# (for insurance filing): _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ (cell): _____

E-mail Address: _____

Who referred you to ACTS, Inc.? _____ May we tell them you came in? _____

Family Information

List all individuals in your immediate family plus family of origin (spouse, children, parents, siblings).

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status (more than one answer may apply)

__ Single (never married) ___ Legally married ___ Unmarried, living together __ Separated

__ Divorce in process ___ Divorced ___ Widowed ___ Annulment

How long in your current status? _____

Assessment of current relationship (if applicable):

____ Excellent _____ Good _____ Fair _____ Poor

Social Relationships

Please list people (first name only) who you consider to be part of your emotional and/or spiritual support system. These may include both individuals and groups of people._____

_____

Spiritual/Religious

How important to you are spiritual matters? _____ Not ____ Little _____ Moderate ____ Much
Are you affiliated with a spiritual or religious group? ___ Yes ___ No
If Yes, describe: _____
Were you raised within a spiritual or religious group? ___ Yes ___ No
If Yes, describe: _____
_____

Education

__ High school grad/GED
__ Vocational: Number of years: __ Graduated: __ Yes ___ No Major: _____
__ College: Number of years: __ Graduated: __ Yes ___ No Major: _____
__ Graduate: Number of years: __ Graduated: __ Yes ___ No Major: _____
Other training: _____
Special circumstances (e.g., learning disabilities, gifted): _____
Currently enrolled in school? ___ Yes ___ No If Yes, where? _____

Employment

If currently employed:
With whom? _____ For how long? _____ Current job position: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

_____
_____

Medical/Physical Health

Please list any current, chronic health conditions/problems:

_____
_____

What, if any, medications (prescribed OR over-the-counter, including herbs) are you taking?

_____

Date of last physical exam: _____ Outcome: _____

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

Please describe your current use of caffeine, nicotine, and alcohol: _____

_____

Please describe any past or present use of recreation drugs (legal or illegal): _____

_____

Legal

Are you currently involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Counseling History and Current Goals

Please list any previous counselors/psychologists/psychiatrists with whom you have worked:

Briefly describe previous counseling experiences (areas of difficulty, progress made):

_____

_____

__

Have you attempted suicide in the past? ___ Yes ___ No

Are you feeling suicidal now? ___ Yes ___ No If Yes, please describe when these feelings started, what you are feeling, etc.:

_____

_____

Have you participated in any treatment programs, support groups, self-help programs? (e.g., drug rehab, Alcoholics Anonymous, anger management). ___ Yes ___ No

If "Yes", please list:

Have you ever been hospitalized for mental health treatment? ___ Yes ___ No

If Yes, please list where and when: _____

Please describe any mental health issues in your family history (parents, grandparents, siblings, aunts/uncles, cousins). These may include depression, anxiety, manic-depression, suicide attempts, mental health hospitalization. _____
_____

****

Please check behaviors and symptoms that occur to you more often than you would like:

__ Aggression
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chest pain
__ Cyber addiction
__Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug/Gambling dependence
__ Eating problems
___ Elevated mood
___ Fatigue
___ Frustration
___ Hallucinations
___ Headaches
___ Heart palpitations
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Other (specify) _____
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Stress
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Intense dreams

CIRCLE any area(s) of concern in your daily life:

Activities of daily living; work; finances; housing; school; family relationships; social relationships; safety; legal; cognitive functioning; physical health; spiritual

Primary reason(s) for seeking counseling services:

What are your hopes/goals for counseling? _____
_____
_____

What have you done prior to coming here to reach your goal(s)?
_____

What other information would you like your counselor to know?
_____

I attest that all information provided above is true.

Client Signature: _____ Date: _____