Adult Intake Form

New Solutions COUNSELING, PLLC

CLIENT INFORMATION

Client name_____ Male_____ Female_____

Address _____ Date of Birth_____ Age_____

City & Zip Code _____ Ethnicity _____ Marital Status _____

Phone (Home) _____ (Cell) _____ (Work) _____

What number may we leave a confidential message? (circle) Home Work Cell Text

Email address: _____ May we send an appointment reminder? Y/N

How did you hear about New Solutions Counseling? _____

EMERGENCY CONTACT

Name_____ Relationship_____

Phone_____ Alternate phone _____

May we contact in case of an emergency? Y/N

EMPLOYMENT/EDUCATION

Current Employer_____ Occupation_____

School attending _____ College _____ Year_____

Highest level of education completed _____ Degree received _____

MEDICAL HISTORY

Primary Care Physician _____ Location_____

Please list health problems including allergies

_____

_____

_____

Please list any hospitalizations (include dates/reasons)

_____

_____

_____

_____

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MEDICAL HISTORY (continued)

Please list all medications you are current taking and the dosage/frequency of use below

MEDICATION	DOSAGE/FREQUENCY

Have you ever been treated for substance abuse? Yes No

Provider and dates of treatment _____

Please check how often you do the following:

Smoke? _____ Never ____ Monthly ___ Weekly Daily _____ Amount _____

Drink Alcohol? _____ Never ____ Monthly ___ Weekly Daily _____ Amount _____

Use Drugs? _____ Never ____ Monthly ___ Weekly Daily _____ Amount _____

REASON FOR SEEKING COUNSELING

Please state the reason you are seeking professional counseling services at this time.

Please list your goals for counseling

1) _____

2) _____

3) _____

4) _____

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SYMPTOM CHECKLIST

Please identify symptoms that relate to the reason you are seeking counseling at this time: (circle any areas of concern)

How would you rate the seriousness of your present situation in severity 1-10

Now _____ 6 Months ago _____ Year ago _____

Anxiety

Anger/Irritabilty

Domestic Violence

Guilt/Feelings of Worthlessness

Poor Concentration

Mood Changes

Sexual Problems

Sexual Assualt/Rape

Depression

Other _____

Thoughts of Suicide/Death

Thoughts of Homicide

Childhood Abuse or Neglect

Alcohol or Drug use (Self or Family)

Grief/Loss

Chronic Pain

Sleeping Problems

Gender Identity Issues

Self-esteem

Relationship conflicts

HAVE YOU EVER EXPERIENCED ANYTHING YOU PERCEIVED AS TRAUMATIC?

_____
_____
_____
_____
_____
_____
_____

(Examples: robbery, rape, death in family, domestic violence, sexual abuse, emotional abuse, physical abuse, severe injury, combat. *(trauma can be either witnessed or experienced).*

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PSYCHIATRIC HISTORY

Have you ever been abused sexually, verbally, emotionally or physically? YES NO

Please explain _____
_____
_____

Are you currently or have you in the past had thoughts of suicide or self-harm (cutting, burning, etc.)? YES NO If current please indicate YES NO

Please explain _____

PRIOR MENTAL HEALTH COUNSELING

Provider/therapist	**Period of treatment (date/year)**

Previous Diagnosis _____
_____

Does your biological mother have a history of mental or emotional problems or substance abuse? If yes, please explain. _____
_____

Does your biological father have a history of mental or emotional problems or substance abuse? If yes, please explain. _____
_____

Is your Mother living _____ or deceased ____? Father _____ living or deceased ____?

Has anyone in your family ever attempted suicide? YES NO Committed suicide? YES NO

Relationship to you _____

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PERSONAL/ SOCIAL HISTORY

Briefly describe your childhood.

_____
_____
_____
_____
_____
_____
_____

(Examples: happy, unhappy, no contact with parent, single parent home, blended family, divorce, alcohol abuse, adopted, sexual, physical, verbal abuse, legal problems, strong religious beliefs).

Briefly describe your father (or father figure) and your relationship with him:

Briefly describe your mother (or mother figure) and your relationship with her:

Siblings:

Name	Age	Describe your relationship with sibling
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Did you have any developmental or learning challenges when you were young? (trouble in school, late reaching milestones, special education services, etc.)? Please describe.

_____
_____
_____

2. Have you ever been arrested, or been involved in a legal situation? Please describe.

_____
_____
_____

3. Please note if you have particular religious, cultural, or spiritual beliefs that you would like the therapist to be aware of. Would you like your spiritual beliefs incorporated into the therapeutic process?

_____
_____

4. Please list hobbies or extracurricular interests you have.

_____
_____

5. What do you consider to be your strengths?

_____
_____
_____

6. What do you consider areas you would like to improve upon?

_____
_____
_____

7. Who in your life provides you support when experiencing stress? (friends, family, etc.)

_____

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_____

_____

8. Please list all marriages and children/stepchildren from each marriage.

Marriage (year)	Years married	Child(ren) names	Age(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. List any additional information that would be helpful for me to better understand you and/or your concerns.

_____

_____

_____