Adult Clinical Intake

Each individual participating in therapy is asked to complete this form as this will expedite the counseling process. This information will remain confidential.

Client Name	Date of Birth	Date

Email Address	Phone Number

Address	Apt #	City	State	Zip

Relationship Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living With Someone

Spouse's Name: _____ Spouse's DOB: _____

Do you have children? ☐ Yes ☐ No If yes, provide information below:

Name	Age and DOB	Lives at

Educational Background

☐ GED ☐ H.S. Diploma ☐ Assoc./Tech Degree ☐ Bachelor's Degree ☐ Post-Grad Degree ☐ Other

If Degree applies, please specify major: _____

Employment History

Employer	Dates Of Employment	Reason For Leaving

Legal History

Have you been arrested? ☐ Yes ☐ No

If yes, indicate what and when: _____

Are you currently on parole or probation? ☐ Yes ☐ No

Medical History

Do you have any significant health issues? ☐ Yes ☐ No

If yes, what is/are the health issue(s)? _____

Are you limited in any way?_____

Date Of Last Medical Exam	Doctor's Name	Doctor's Phone Number

Psychiatric History

Have you ever been in therapy before? ☐ Yes ☐ No If yes, please specify:

Dates	With Whom	Presenting Issues	Diagnosis

Medication History

Are you currently taking any medications? ☐ Yes ☐ No If yes, please specify:

Medication	Condition	Dosage	Dates Of Usage	Side Effects	Physician

Alcohol / Drug Use

Do you currently use alcohol or drugs? ☐ Yes ☐ No If yes, please specify:

Type	Dosage	Dates Of Usage	Frequency

When did you start using drugs or alcohol? _____

What has you past use of alcohol been like? _____

Suicide Risk

Have you ever thought about or have tried to hurt yourself? ☐ Yes ☐ No

If yes, when? _____ How many times? _____

How or what did you plan to do? _____

What were the circumstances at the time? _____

Has anyone close to you committed suicide? ☐ Yes ☐ No

If yes, who, how and when? _____

Abuse History

have you ever been physically, emotionally, or sexually abused? ☐ Yes ☐ No

If yes, briefly explain who, what and when: _____

_____

Symptom Checklist

Check the following symptoms that you have experienced in the last thirty days:

☐ Sleep Disturbance	☐ Weight Change	☐ Tension
☐ Withdrawl	☐ Change in Eating Behavior	☐ Lack of Motivation
☐ Physical Complaints	☐ Easily Annoyed or Irritated	☐ Restlessness
☐ Uncontrolled Temper Outbursts	☐ Guilt, Remorse, Shame	☐ Negative / Intrusive Thoughts
☐ Decreased Sex Drive	☐ Uncontrolled / Unprovoked Crying	☐ Lack of Concentration
☐ Feeling Down or Depressed	☐ Generalized Anxiety	☐ Difficulty with Decisions
☐ Specific Anxiety or Phobia	☐ Panic Attacks	☐ Feeling Of Being Watched
☐ Nervousness	☐ Fear	☐ Excessive Worry

Support Systems

Do you have people that you can turn to for support? ☐ Yes ☐ No

If yes, who? _____

What do you feel are your strengths? _____

Briefly explain why you are seeking counseling at this time: _____

What do you hope to achieve through counseling? _____