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ADULT INTAKE ASSESSMENT FORM

Please answer all of the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: _____ Today's Date: ___/___/_____
❑ Male ❑ Female Date of Birth ___/___/_____ Age: ____

Home Address: _____
City: _____State: _____ Zip Code: _____
Home phone: _____ Cell/other phone:_____
Is it OK to contact you at home? ❑ Yes ❑ No OK to leave a message? ❑ Yes ❑ No
Special calling instructions? _____

Business phone: _____
Is it OK to contact you at work? ❑ Yes ❑ No OK to leave a message? ❑ Yes ❑ No

Special calling instructions? _____

How did you learn about my services? _____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: ❑ employed ❑ retired ❑ disabled ❑ student ❑ homemaker ❑ unemployed
If/When employed, what type of work do you do? _____
Current employer: _____ Years on Current Job: _____

Are you currently having difficulties on the job because of (Check if yes):
❑ emotional problems?
❑ substance abuse?

Have you ever had difficulties at work because of (Check if yes):
❑ emotional problems?
❑ substance abuse?

If yes to any of the above, please explain: _____

_____

_____

Ever in Military Service: ❑ yes ❑ no
Currently in military? ❑ yes ❑ no Branch: _____
If you served in combat, when did you serve? _____
Type of discharge: _____
Reason for discharge: _____

MARITAL STATUS

Marital/relationship status (Check one): ❑ Married; ❑ Live with partner (check if same ___ or opposite___ sex); ❑ Single; ❑ Separated/Divorced; ❑ Widowed; or ❑ Other: _____

MARITAL STATUS (continued)
If previously married, please provide dates of Marriage(s): _____
_____
Number of years currently married: _____

Are you experiencing any problems/stresses in your current marriage/relationship? ❑ yes ❑ no
Did you experience any problems/stresses in your previous marriage/relationship? ❑ yes ❑ no
Comments regarding stresses in current or previous marriage(s)/relationship(s): _____
_____
_____

If you have had problems in the past, what do you think caused those relationships to end? _____
_____
_____

EDUCATION

Last grade completed in school/college is/was: _____ Degree: _____
Are you currently enrolled in school? ❑ yes ❑ no Major/focus: _____
Do you have any special training, skills, or certification? (list): _____
_____
_____

Do you have any problems reading or writing? ❑ yes ❑ no

Do you have any difficulty understanding (check any that apply): ❑ spoken instructions
❑ written instructions
❑ demonstrated instructions

How do you learn best? _____
_____
What was school like for you? _____
_____
Describe any difficulties or problems you had/have in school: _____
_____
_____

REASON FOR SEEKING
Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly. _____
_____
_____
_____

What has happened to cause you to seek help Now? _____
_____
_____
_____
_____

What do you hope to be able to do or achieve as a result of treatment? _____
_____
_____
_____
_____

What do you consider to be the other stresses in your life? _____
_____
_____
_____
_____

HISTORY OF THE PROBLEM

When did you first start experiencing the problem(s) that bring you to the clinic today? _____

_____

_____

How often does the problem occur? _____

How long does it last? _____

Do you currently have thoughts of harming yourself? ❑ yes ❑ no

Do you currently have thoughts of wishing you were dead? ❑ yes ❑ no

Do you currently have urges to hurt, harm, or kill someone else? ❑ yes ❑ no

If yes, whom? _____

Have you ever seriously considered suicide or felt like harming someone else? ❑ yes ❑ no

If yes, please explain: _____

_____

_____

Do you have any problem with any of the following: ❑ overspending ❑ food binging

❑ intentional vomiting ❑ yelling/threatening ❑ risk taking/endangering self or others

❑ hitting, shoving, choking, or hurting others ❑ throwing or breaking things

❑ stealing ❑ internet overuse or misuse ❑ sexual feelings/behaviors

Have you ever had previous therapy/counseling of any kind? ❑ yes ❑ no

If yes, when and for how long? _____

_____

What concerns did you address in previous therapy? _____

_____

_____

Have you ever been hospitalized for emotional problems? ❑ yes ❑ no

Have you ever been hospitalized for substance abuse problems? ❑ yes ❑ no

If yes to either of the above, when, where, and for how long were you hospitalized? _____

_____

_____

Were any of your previous treatment experiences helpful? ❑ yes ❑ no

Please explain how you benefited or did not benefit from previous treatment: _____

_____

_____

What medication(s), if any, have you found helpful in managing your emotional problems? _____

_____

Have you had any experience with self-help support groups? ❑ yes ❑ no

If yes, please explain when, which ones, and whether or not you found them helpful:

_____

_____

SUBSTANCE USE HISTORY

Have you ever experienced a problem with alcohol, drugs, or prescription medications? ❑ yes ❑ no

If yes, please explain: _____

_____

_____

_____

_____

SUBSTANCE USE HISTORY (continued)

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications?
❑ yes ❑ no If yes, please explain: _____
_____
_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? ❑ yes ❑ no
If, yes, please explain: _____
_____
_____

Have you had any problems related to use of alcohol/drugs in the past year? ❑ yes ❑ no
If, yes, please explain: _____
_____
_____

Has drinking or drug use ever caused you problems in the following areas (check if yes):
❑ family ❑school ❑ employment ❑ legal ❑ emotional ❑ social ❑ financial ❑ behavior
❑ physical health ❑ other, please describe: _____
_____
_____

FAMILY BACKGROUND

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN ❑

Names of children	Living with you?	Age	Grade	School
1. _____	❑ yes ❑ no	____	_____	_____
2. _____	❑ yes ❑ no	____	_____	_____
3. _____	❑ yes ❑ no	____	_____	_____
4. _____	❑ yes ❑ no	____	_____	_____
5. _____	❑ yes ❑ no	____	_____	_____

Other than any children already indicated above, who lives in your household? _____
_____
_____

Please describe your relationships with other family members:

Relationship	Living?	Frequency of contact?	Describe quality of relationship
Father	❑ yes ❑ no ❑ n/a	_____	_____
Mother	❑ yes ❑ no ❑ n/a	_____	_____
Step-father	❑ yes ❑ no ❑ n/a	_____	_____
Step-mother	❑ yes ❑ no ❑ n/a	_____	_____
Spouse/partner	❑ yes ❑ no ❑ n/a	_____	_____
Sister(s)	❑ yes ❑ no ❑ n/a	_____	_____
Brother(s)	❑ yes ❑ no ❑ n/a	_____	_____
Other	❑ yes ❑ no ❑ n/a	_____	_____

Whom were you raised by? _____ Were you adopted? ❑ yes ❑ no
Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): _____
_____
_____
_____

FAMILY BACKGROUND (continued)

What family member(s) are you closest to now? _____
_____

As you were growing up, what adult(s) stood out as people you could really trust? _____
_____
_____

Check the statement(s) below that describe the type of family you grew up in:

❑ overly close family ❑ no "breathing room" ❑ everyone was in everyone else's business
❑ no privacy ❑ boundaries not respected ❑ Comfortably close family ❑ loving
❑ shared many positive experiences ❑ supportive ❑ distant, everyone did their own thing
❑ not much time spent together ❑ not a lot of support ❑angry, lots of fighting/hostility
❑ verbal abuse and conflicts ❑ violence ❑ frightening ❑ scared to make mistakes
❑ other descriptors: _____

Have any biological relatives ever had any emotional problems or substance abuse? ❑ yes ❑ no
If yes, please explain: _____
_____
_____

Has anyone in your family ever attempted or committed suicide? ❑ yes ❑ no
If yes, please explain: _____
_____

RACE/ETHNICITY

	Self	Spouse
European-American	_____	_____
African-American	_____	_____
Hispanic-American	_____	_____
Native-American	_____	_____
Asian-American	_____	_____
White	_____	_____
Other _____	_____	_____

RELIGIOUS AFFILIATION

	Self	Spouse
Catholic	_____	_____
Jewish	_____	_____
Muslim	_____	_____
Protestant	_____	_____
Non-Denominational	_____	_____
Eastern (e.g., Hindu, Buddhist)	_____	_____
Other _____	_____	_____

HEALTH/MEDICAL INFORMATION

Physician	Address & Telephone #	Approx Date of last visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____
_____
_____

Do any of these problems affect your everyday life? ❑ yes ❑ no If yes, how so? _____
_____
_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____
_____
_____

HEALTH/MEDICAL INFORMATION (continued)

Have you ever had a serious head injury? ❑ yes ❑ no If yes, describe: _____

_____

_____

Are you allergic to any medications? ❑ yes ❑ no If yes, which one(s): _____

_____

_____

List all medications that you currently use:

Medication(s)	Dosage (amount and times per day)	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any "alternative" therapies/treatments you are currently using and the reason for each:

_____

_____

Have you ever had or do you now have a problem with any of the following? (Check all that apply):

General

❑ Recent Fever/Chills	❑ Diabetes	❑ Cigarette Smoking
❑ Chronic Fatigue	❑ Cancer	❑ Other Tobacco Use
❑ Frequent or Terrifying Nightmares	❑ Drug Reaction	❑ Alcohol Use
❑ Night Sweats	❑ Emotional Problems	❑ Drug Use
❑ Insomnia or Sleep Problems	❑ Allergies	❑ Suicide Attempt(s)
❑ Chronic Pain _____	❑ Exposure to Trauma (Type: _____)	

Gastrointestinal/Hepatic/Endocrine

❑ Nausea	❑ Hepatitis	❑ Weight Loss/Gain
❑ Gastritis	❑ Constipation	❑ Change in Appetite
❑ Ulcers	❑ Diarrhea	❑ Anemia
❑ Vomiting Blood	❑ Colitis	❑ Thyroid Problems
❑ Pancreatitis	❑ Rectal Bleeding	❑ Always Thirsty
❑ Gall Bladder/Stones	❑ Hemorrhoids	❑ Swollen Glands
❑ Jaundice	❑ Liver Problems	❑ Low Blood Sugar

Musculoskeletal	Cardiovascular	Pulmonary
❑ Broken Bones	❑ Angina	❑ Chest Pains/Pressure
❑ Bad Back	❑ Fainting	❑ Shortness of Breath
❑ Herniated Disk	❑ Lightheadedness	❑ Cough
❑ Muscle Weakness	❑ Irregular Heart Beat	❑ Wheezing/Asthma
❑ Joint Pain	❑ High/Low Blood Pressure	❑ Coughing Blood
❑ Arthritis	❑ Rheumatic Fever	❑ Tuberculosis
❑ Gout	❑ Heart Valve Problems	❑ Pneumonia

HEALTH/MEDICAL INFORMATION (continued)

Neurological
- ❑ Headaches
- ❑ Migraines
- ❑ Skull Fracture
- ❑ Epilepsy
- ❑ Stroke
- ❑ Paralysis
- ❑ History of Head Injury
- ❑ Double Vision
- ❑ Memory Loss
- ❑ Unsteady Gait

Urinary/Genital
- ❑ Frequent Urination
- ❑ Burning on Urination
- ❑ Weak Urinary System
- ❑ Incontinence
- ❑ Urinary Tract Infection
- ❑ Blood in Urine
- ❑ Kidney Infection
- ❑ Penis/Vaginal Discharge
- ❑ Menstrual Difficulties
- ❑ Sexual Difficulties
- ❑ STD

Skin/Sensory Systems
- ❑ Sores/Abscesses
- ❑ Skin Rash
- ❑ Eye Trouble
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Perforated Septum
- ❑ Nose Bleeds
- ❑ Gum Bleeding
- ❑ Mouth Sores
- ❑ Difficulty Swallowing

INTERESTS AND ACTIVITIES

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____

_____

_____

_____

Please describe your personal strengths and positive characteristics: _____

_____

_____

_____

_____

_____

Other information you feel is important and wasn't asked about: _____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY

Name(s)	Relationship to Client	Telephone No.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for your time and cooperation.

Marie D. Guillory, M.Ed., LPC, RTC