Consulting & Counseling Associates

Adult Intake Information Form

General Information

Today's Date_____

Name_____ Preferred Name _____
Date of Birth_____ Age_____ Birth Sex_____ Gender (optional)_____
Home Address_____
City_____ State_____ Zip Code_____
Occupation/Employer_____ Religious Preference_____
Referred By_____ Soc. Security #:_____

Please describe the reason for your visit_____
_____

Contact Information

Check (✓) which method you prefer and only provide the information if you agree to us contacting you via the following:
☐ Home Phone (_____)_____ ☐ Cell Phone (_____)_____
☐ E-Mail Address_____
Emergency Contact: _____ Relationship _____Phone (_____)_____

Relationship & Family History

☐ Never Married
☐ Partnered How long_____ ☐ Separated Date_____
☐ Engaged Date_____ ☐ Divorced Date_____
☐ Married Date_____ ☐ Widowed Date_____

Please identify any additional divorces or past significant relationships: _____
_____

Spouse's Name_____ D.O.B._____ Age_____ Soc. Security #_____
Spouse's Occupation/Employer_____

Family and Household Composition: Please list immediate family and significant relationships.

Name	Relationship	Age	Residence (identify *Home* or *City/State*)	Mental/Physical Issues (specify)

Please check (✓) if any of the following apply to your family's history:
☐ Mental illness ☐ Emotional abuse ☐ Sexual abuse ☐ Physical abuse ☐ Alcohol or drug abuse

Consulting & Counseling Associates

Adult Intake Information Form

Personal History

Please list any significant stressors that you have experienced (job change or loss, family illness or injury, accidents, deaths, moves, violence, crime victimization, etc.)_____

_____

_____

Please list any previous mental health services (outpatient and/or inpatient) you have received.

Provider/Agency/Hospital	Dates	Reason

Medical History

Primary Physician_____ Date of last physical examination_____

May we contact your physician? ☐ Yes ☐ No

Please describe any serious illnesses, injuries or surgeries_____

_____

Please list all medications you are currently taking and for what purpose.

Medication	Dosage	Date Prescribed	Purpose	Prescribed By

Please describe any medication side effects you are experiencing_____

_____

Please describe any allergies that you have_____

_____

Are you receiving any type of disability benefits? ☐ Yes ☐ No

Please list any current alcohol and/or drug use.

Name of Drug	Average Amount Used	Frequency of Use	Date of Last Use

Please check (✓) the following:

☐ Yes ☐ No Have you ever felt guilty or concerned about your alcohol or drug use?
☐ Yes ☐ No Have you ever felt you should cut down your alcohol or drug use (including prescription drugs)?
☐ Yes ☐ No Has a friend or relative discussed concerns about your alcohol or drug use?
☐ Yes ☐ No Have you experienced legal problems due to your alcohol or drug use?

Consulting & Counseling Associates

Adult Intake Information Form

Presenting Problems Checklist

Please check (✓) all that apply:

- ☐ Anger/Frustration
- ☐ Indecisiveness
- ☐ Change in Sleep Patterns
- ☐ Chronic Fatigue
- ☐ Overeating
- ☐ Loss of Appetite
- ☐ Vomiting after Meals
- ☐ Poor Self-Esteem
- ☐ Anxiety
- ☐ Nightmares
- ☐ Dizziness
- ☐ Fear of Rejection
- ☐ Tension Headaches
- ☐ Difficulty Concentrating
- ☐ Disorientation (not knowing where/who you are)
- ☐ Emptiness
- ☐ Impulses to Hurt Myself or Others
- ☐ Lack of Energy
- ☐ Confusion
- ☐ Visual and/or auditory Hallucinations
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Heart Palpitations
- ☐ Alcohol/Drug Abuse
- ☐ Hyperventilation
- ☐ Worrisome Thoughts
- ☐ Intrusive Thoughts
- ☐ Menstrual Distress (PMS)
- ☐ Nausea/Diarrhea or Other Abdominal Distress
- ☐ Muscle Tension
- ☐ Depression or Extreme Sadness
- ☐ Social Withdrawal
- ☐ Irritability
- ☐ Trembling
- ☐ Suicidal Thoughts
- ☐ Compulsive Behaviors
- ☐ Memory Loss
- ☐ Mood Swings
- ☐ Suspiciousness
- ☐ Weight Gain/Loss
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Parental Conflicts
- ☐ Work/School Problems
- ☐ Other:_____

On-Going Issues

☐ On-going Difficult Interactions with:
_____
_____
_____

- ☐ Significant Loss (Identify)_____
- ☐ Infertility Issues
- ☐ Transgender Issues
- ☐ Insufficient Friendships
- ☐ Other:_____

Please check (✓) if you are currently involved with any of the following organizations/agencies:

☐ Child Protective Services	☐ Police	☐ Probation Officer	☐ Litigation/Court
☐ Big Brother/Big Sister	☐ SCAN	☐ Social Services	☐ Erin's House
☐ Council on Aging	☐ Hospice	☐ Other/Specify_____	

Please describe any pending legal matters (include visitation/custody proceedings)_____

_____

_____