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: _____ DOB: _____/_____/_____ Date: _____/_____/_____

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? _____