Adult Intake Form

Please answer all questions. Use the back for additional information if necessary. You will have a chance to explain any answers during our intake session.

Name: ________________________________ Today's date: ___________________________

Nickname/Name you want to be called: ____

Home Address: ______________________________City: ____________________________

State: __________________ Zip: _______________

Home Phone: _________________________Cell: ___________________________________

Other Phone: _____________________ Email: ____________________________________

Birth Date: ________________ Age: _________

Identified Gender & Preferred Pronouns: ________________________Biological Sex: _____

Marital Status: ______________

Is it OK to send confidential information to your e-mail address? ☐ Yes ☐ No

Is it OK to leave a voicemail? ☐ Yes ☐ No

Is it OK to communicate through texting? ☐ Yes ☐ No

With whom do you currently live? (Check Which Apply)

☐ Alone ☐ With Partner ☐ Children ☐ Parents/Other Dependant ☐Other, please list:

____

____

____

Partner's Name (If Applicable): ____

Child/rens Names (If Applicable):

____

____

Are you currently employed? ☐ Yes ☐ No

IF yes, where? ____

If you are currently employed, do you enjoy your job? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No

If yes, where and what do you study?: ____

Religious/Spiritual Affiliation (If Applicable): ___________________________________

Did you participate in the decision to start counseling? ☐ Yes ☐ No

HAVE YOU EVER HAD THOUGHTS OF WANTING TO HURT OR KILL YOURSELF? Y or **N**
If yes, please answer the following questions:
Are you feeling like you want to hurt or kill yourself right now? **Y** or **N**
When was the last time you thought about hurting or killing yourself? __________________
Do you have a plan? **Y** or **N**

HAVE YOU EVER HAD THOUGHTS OF WANTING TO HURT OR KILL ANYONE ELSE? Y or **N**
If yes, please answer the following questions:
Are you feeling like you want to hurt or kill anyone right now? **Y** or **N**
When was the last time you thought about hurting or killing someone? __________________
Do you have a plan? **Y** or **N**

IS THERE A KNOWN FAMILY HISTORY OF ANY OF THE FOLLOWING? (Circle all that apply)

Sexual abuse	*Physical abuse*	*Emotional abuse*	*Rape*	*Alcoholism/drugs*
Violence	*Sleep disorders*	*Eating disorder*	*Physical conditions*	*Mental health history*

IN THE PAST YEAR HAVE YOU EXPERIENCED DIFFICULTIES IN ANY OF THE FOLLOWING AREAS? (Circle all that apply)

Marriage/partner	*Family*	*Job/School*	*Health*	*Finances*	*Friendships*	*Legal*	*Mood*
Anxiety	*Eating habits*	*Spirituality*	*Anger*	*Alcohol*	*Drug(s)*	*Sexual*	*Caffeine*
Smoking	*Aggression*	*Impulsiveness*	*Depression*	*Loneliness*	*Hopelessness*	*Life Transitions*	*Grief/ Loss*

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Previous History

Please describe what brings you to counseling currently.

____

____

____

What do you hope to gain through counseling?

____

____

____

What have you already done to deal with the difficulties?

____

____

____

Have you had previous psychological counseling or psychiatric help? Please check all that apply.

☐ Individual counseling? If yes, when and where?

____

☐ Group/Family Counseling? If yes, when/where?

____

☐ Hospitalization(s)? If yes, when/where?

____

List any medications and dosages that pertain to your mental well-being:

____

____

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List any other medications and dosages you currently take:

List any significant health problems for which you have been treated in the past and then place a check by those problems for which you are currently being treated:

List any serious or chronic illness, operations, or traumatic accidents you have had:

Are you currently, or have you at any time within the last 12 months been under the care of a physician? ☐ Yes ☐ No

If so, for what condition?

Who is your doctor? ______________________________

Would you like me to speak with your doctor? ☐ Yes ☐ No
If yes, please fill out an ROI if you are 15 years or older or have your guardian sign an ROI.

What are your biggest strengths?

____

Do you exercise? ☐ Yes ☐ No
If yes, for how long and how many times per week?

____

Do you smoke? ☐ Yes ☐ No
If yes, what do you smoke?____
How often? ____

Do you consume alcohol? ☐ Yes ☐ No
If yes, how often? ____

Do you take any non-prescribed (recreational) drugs? ☐ Yes ☐ No
If yes, what and how often?____

Interactions between client and counselor are confidential. Unless I have permission from you, what we talk about will be private; I will not discuss it with anyone else. Our discussion will be private and confidential, even if you don't mind your parents knowing about anything that we talk about. There are four major exceptions to confidentiality that Colorado law requires all mental health professionals to report when there exists:

1. Incidence(s) of child or elder abuse or neglect.
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Client's (signature): ________________________________ Date: ___________________

IF you are **under** the age of 15 years old, must provide guardian's consent for mental health services.

Parent(s)/Guardian(s): ______________________________ Date: ___________________

Counselor's (signature): ______________________________ Date: ___________________