Adult Intake Form

Demographics

Name: _____ Date: _____

Address: _____ City:_____

State: _____ Zip: _____ County: _____

It is customary at NewSong practice to mail a letter of termination at the end of treatment. If the above is not at a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here: _____

_____

Phone (H) _____ (C) _____ (W) _____

Email: _____

Preferred Method of Contact (Circle One): Phone Call Phone Text Email

Age: _____ DOB:_____

Race: American Indian/Alaska Native, African American/Black, Asian, White, Other:_____

Religious Affiliation: _____

Which best describes you: Employed Disabled Student Other: _____

Employer: _____ Occupation: _____

Social Security: _____

Marital Status (circle one) : Single Married (years married _____) Divorced Widowed

Emergency Contact Information:

Name: _____

Relationship: _____ Phone:_____

- I authorize release of information to this emergency contact individual(s) as needed for emergency purposes: yes____ no _____

Name _____ Date of Birth _____

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

Referred by: _____

Reason for seeking counseling: _____

_____

_____

Goals for this treatment/episode (in other words, what would you like to see change or be different about yourself?): _____

_____

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

_____

_____

Allergies: _____

Physician: _____ Phone Number: _____

Fax Number: _____

Pharmacy : _____

Are you on disability? Yes No Please describe: _____

_____

Are you currently taking medication for a mental or emotional condition? Yes No

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? Yes No

If yes, please list where and when: _____

_____

In thinking about the last two (2) weeks, circle what best describes your mood:

Calm Angry Worried Hopeless Helpless Mood Swings

Other: _____

Name _____ Date of Birth _____

Please indicate any of the following problems/disorders which any of your blood RELATIVES have had by checking the corresponding box:

	Mother	Father	Sister	Brother	Grandfather	Grandmother
ADHD/ADD						
Alcoholism						
Anemia						
Anxiety						
Asthma						
Cancer						
Depression						
Diabetes						
Drug Addiction						
Epilepsy						
Fears/Phobias						
Hepatitis						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Low Blood Pressure						
Manic Depression						
Nervous Breakdown						
Obsession Compulsion with specific activities						
Psychiatric Treatment						
Suicide						
Stroke						
Venereal Disease						

Are your parents divorced? Yes No If yes, how old were you? _____

Briefly describe your childhood: (i.e. happy, chaotic, troubled) _____

_____

_____

Are childhood events contributing to your current problems? Yes No

Please explain _____

_____

Social Supports

How satisfied are you with the support you receive from your family/friends? (Please circle)

Very satisfied Satisfied Very Unsatisfied Unsatisfied

Name _____ Date of Birth _____

How many close friends do you have and how are they helpful? _____

_____

Have your current difficulties affected your family/friends/co-workers? Yes No

Education History

Years of education completed: _____ Degree(s): _____

Did you experience any issues or difficulties in school? Yes No

If yes please briefly describe _____

_____

_____

Chemical Substance Use and Abuse Information	Yes	No	If yes, please explain.
Have you used alcohol or drugs in the last 30 days?			Substance of Choice and when was your last use?
Have you been in treatment in the past			Please circle: IOP, PHP, OP, Support, AA, Hospitalization, Other
Have you been hospitalized for overdose or withdrawal symptoms?			Where/when?
Do you have a history of seizures during withdrawal?			Explain:
Have you ever been to a residential treatment center?			Where/when?
Have you been in treatment for detox?			Where/when?

Legal Information

Are there any pending legal cases against you? Yes No

If yes, what is the charge? _____

_____

Please include court and attorney's name and contact information: _____

_____

Is Child Protective Services involved in your family? Yes No

Name _____ Date of Birth _____

If yes, please include your social worker's name and contact information: _____

_____

_____

Positive Coping Skills

What type of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. (i.e.: journaling, exercising, workbooks, prayer, support groups): _____

_____

_____

What are some of your hobbies/interests?_____

_____

_____

Previous Counseling? Yes No

Who and Where:_____

_____

Release of Information signed to talk with previous counselor(s) Yes No

How would you describe your previous counseling experience? _____

_____

_____

Would you say it was an effective, successful treatment? _____

_____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

_____

How long do you think therapy should last? _____

How long are you able to commit to therapy? _____

What do you think therapy is all about? _____

_____

_____

Client's Signature: _____ Date: _____