

ADULT INTAKE FORM

Name _____ D.O.B. _____ Age _____ Sex M/F Date _____

Street Address _____ Phone (h) _____

City, State, Zip _____ Phone (w) _____

Email address _____ Phone (cell) _____

For confidentiality, when and where do you prefer to be reached?

Current Marital status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

Date of Current Marriage/Separation: _____ Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____

Number of Children and ages:

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Emergency Contact: Name _____ Phone _____

Relationship to you _____

Who referred you or how did you hear about this service? _____

REASONS FOR SEEKING HELP

What concerns have led you to pursue counseling?

Where are your concerns causing the most problems for you? Check all that apply:

Home Work Marriage Other Relationships God

When did your present concern begin to be a problem for you?

Have any concerns about you been identified by others? What have they said?

Please indicate which of the following areas are currently problems for you. Check **all** that apply:

- Under too much pressure/feeling stressed
- Excessive anxiety or worry
- Feeling lonely
- Angry feelings
- Concerns about finances
- Feeling "numb" or cut off from emotions
- Angry outbursts
- Excessive fear of specific places/objects
- Difficulty making friends
- Feeling as if you'd be better off dead

- Feeling manipulated or controlled by others
- Difficulty making decisions
- Loss of interest in sexual relationships
- Feeling sexually attracted to members of your own sex
- Concerns about physical health
- Blackouts or temporary loss of memory
- Insomnia (no sleep) or Hypersomnia (sleep all the time)
- Loss of appetite/increased appetite
- Lacking self-confidence
- Issues with food and/or weight
- Abuse of alcohol and/or non-prescription drugs
- Delusions
- Feeling distant from God
- Hallucinations
- Inability to concentrate while at school/work
- Crying spells
- Nightmares
- Loss of interest in usual activities/lack of motivation
- Obsessions or compulsions with specific activities
- Inability to control thoughts
- Feeling trapped in rooms/buildings
- Hearing voices
- Feeling that people are "out to get you" or that you're being watched
- Other: _____

Please rate the severity of your present concerns on the following scale (circle one):
 Mild - Moderate - Severe - Totally Incapacitating

MEDICAL/HEALTH INFORMATION

How would you rate your current physical health? Excellent Good Fair Poor

Date of last physical examination: ____/____/____

Are you currently experiencing any physical problems?
 (e.g. headaches, body aches, stomach problems, chronic pain)

Yes No

If yes, please explain:

MEDICATION(S)

Over-the-counter or prescription _____

Dosage or frequency of use _____

Previous hospitalizations for medical reasons: Date _____ Reason _____

Date _____ Reason _____

Have you ever been hospitalized for psychiatric purposes? Yes No

If yes, please explain including name of hospital, location and dates:

Have you ever attempted suicide? _____ If yes, when? _____ Did you receive care following this attempt? _____

Have you received counseling before? Yes No Permission to contact previous counselor: Yes No

If yes, please list names of any previous counselors or therapists, including dates and contact number:

How do you feel about the results of your previous counseling? Do you wish something would have been done differently?

What do you hope to gain from counseling?

OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation _____ Employer _____

If currently a student: Field of Study _____ Part-Time Full-time

Institution, University or College _____

Highest level of education: _____

RELIGIOUS BACKGROUND

Do you believe in God? Yes No

How would you characterize your religious upbringing? _____

What words or phrases would you use to describe your relationship with God?

Have you attended the six-week Discovery Class at The Crossing and signed the membership covenant? _____

How often do you attend church services? _____

Are you involved in a small group or Bible study? _____
