Client Name: _____ **Age:** _____ **Date:** _____

Aspects of Life
COUNSELING SERVICES

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Adult Intake Information

(to be completed by client)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

Name: _____ Date of Birth: _____

Address: _____

Telephone number(s)

Home: _____ Can I leave a message at this number: ☐ Yes ☐ No

Cell: _____ Can I leave a message at this number: ☐ Yes ☐ No

Can I send text to this number: ☐ Yes ☐ No

Work: _____ Can I leave a message at this number: ☐ Yes ☐ No

Can you be reached by Email: ☐ Yes ☐ No Email address: _____

Occupation: _____ Employer: _____

How satisfied are you with your job? _____

Highest level of education: _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

_____

_____

What do you wish to accomplish through the process of therapy? _____

_____

_____

_____

Approximately how many visits do you think it will take? _____

Marital/Relationship Status (check all that apply):

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried

☐ Single ☐ Long term relationship ☐ Cohabitating ☐ Other_____

Current partner's name: _____

Partner's occupation: _____

Length of relationship: _____

How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, foster, step, etc.)? ☐ Yes ☐ No

If yes, please provide names and ages: _____

_____

_____

Do your children currently live with you? ☐ Yes ☐ No

If no, where do they live? _____

How often do you see them? _____

If you have been previously married, please complete the following:

1st Marriage Date began: _____ Date ended: _____

Ex-spouse's name: _____

Children: ☐ Yes ☐ No

Reason for divorce: _____

2nd Marriage Date began: _____ Date ended: _____

Ex-spouse's name: _____

Children: ☐ Yes ☐ No

Reason for divorce: _____

Have you ever been in therapy before? ☐ Yes ☐ No

If yes, briefly describe the reason(s), date(s), and length of treatment: _____

_____

_____

Was it a positive experience? ☐ Yes ☐ No

What did you like/not like about it? _____

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, please describe briefly: _____

_____

_____

Have you ever seriously contemplated suicide? ☐ Yes ☐ No

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Do you have any chronic illnesses, medical conditions, or injuries? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you presently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

_____

What do you enjoy doing in your spare time? _____

_____

Are there things that you use to do, or would like to do, but currently don't? _____

_____

How would you describe your spiritual or religious beliefs? _____

_____

Is there anything else you think would be important for me to know about you or your family?

_____

_____

_____

Did someone refer you? ☐ Yes ☐ No

If yes, who? _____

May I contact him or her? ☐ Yes ☐ No

Please circle any of the following that presently cause you difficulty:

Assertiveness	Health problems	Career choices	Stomach problems
Parenting	Alcohol abuse	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Bedwetting	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Education	Divorce	Relaxation	Ambition
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headache	Tiredness
Anxiety	Finances	Appetite	School
Unhappiness	Fears	Work	Confusion
Premarital	Food	Self-control	Sadness
In-laws	My past	Guilt	Other: _____

_____ _____

PRINT NAME OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT | RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT | DATE