Fairview Counseling Centers Adult Intake Form

Please complete as much of this form as you can. Bring the form to your first session.
This information is vital to the treatment process.

Your information

Name_____ Age_____ Date of birth_____
Month/Day/Year

Referred by _____ Emergency contact name_____

Relationship to emergency contact_____ Phone (____)_____

To be completed by therapist:

MR#: _____ Account #: _____ Date of service: _____
People present at the initial interview: _____
(Name and relationship)

- ❑ Reviewed intake form and referral information.
- ❑ Client verbalizes understanding of informed consent and privacy policies.
- ❑ Completed release of information as indicated.

Is there a phone number where your therapist can leave you a *detailed* message? ❑ yes ❑ no
If yes, what is the number? _____

Present concerns

What has led you to seek help at this time? _____

_____

_____

Have you already tried to resolve these concerns? If so, what did you do and how did it work?

_____

_____

_____

Who do you go to for support (family, friends, faith or spirituality, support or self-help groups)?

_____

_____

What strengths or resources do you have that will help you succeed in counseling? (Examples include commitment, strong family support, intelligence, good social support, church, friends, etc.)

_____

_____

_____

What might prevent your success in counseling? (Examples include few friends, financial stress, lack of social support, lack of family support, etc.)

_____

_____

_____

Social History

Please check the item that best describes you below:

❑ Single ❑ Married ❑ Remarried ❑ Partner or significant other
❑ Separated ❑ Divorced ❑ Widowed ❑ Other _____

Please describe your living situation. Check all that apply:

❑ With spouse ❑ With partner or significant other ❑ With children ❑ With parents
❑ Alone ❑ With roommate ❑ Other_____

Please tell us if you are working. Check all that apply:

❑ Employed ❑ Unemployed ❑ Full-time parent ❑ Volunteer or other

If you work outside the home (in a paying job or as a volunteer), describe the job and how long you have held it: _____

Which of the following best describes you? *(Optional)*

❑ African ❑ African American ❑ Asian ❑ Hawaiian or Pacific Islander
❑ Latino/Latina ❑ Native American ❑ Bi-racial ❑ White ❑ None of the above

Tell us about your childhood:

Where did you grow up? _____

Were your parents always married, or was there a divorce? _____

If they divorced, how old were you at the time? _____

How many siblings do you have? _____ What was your birth order? _____

How would you describe your childhood? _____

_____

_____

Tell us about your current family. Please list the members of your family and household below.

Name	Age	Relationship	Living in same house? (circle)
			Yes No
			Yes No
			Yes No

How would you describe relationships in your current family? _____

_____

_____

Tell us about any other marriages or committed relationships you have had.

Length of relationships: _____

Do you have children from other relationships? ❑ yes ❑ no

If yes, give names and ages (unless already named above): _____

_____

Legal status

Have you ever been involved with the legal system (child custody, order for protection, DWI, etc.)?
❑ yes ❑ no

If yes, please describe: _____

_____

_____

Education

Please list the highest grade you have completed: _____

Do you have learning problems in any of these areas? ❑ Speech ❑ Hearing ❑ Reading
❑ Writing ❑ Concentration ❑ Attention ❑ Other: _____ ❑ None

If you have problem areas or a preferred way to learn, please describe:

_____

Ethnicity, culture and religion

Please share any ethnic, cultural or religious concerns that may be helpful to your therapist:

_____

Is English your preferred language? ❑ yes ❑ no

If no, list language: _____

Would you like an interpreter or other support involved in your therapy? ❑ yes ❑ no

Mental health and chemical dependency in your family of origin

Please list any relatives (blood relatives) who have had mental health issues.

Depression: _____

Bipolar/manic depression: _____

Anxiety (panic attacks, obsessive-compulsive disorder, phobias): _____

_____

Schizophrenia: _____ Suicide: _____

Eating disorder: _____ Attention deficit disorder: _____

Drug or alcohol abuse or dependency: _____

_____

Your mental health and chemical dependency history

Have you ever had therapy, counseling, hospital treatment or medicines for:

Mental health problems? ❑ yes ❑ no Chemical dependency? ❑ yes ❑ no

If yes, when, where and what was being treated?

Date	**Treated For**	**Treatment Type** *(hospital, medicine, counseling)*	**Provider or Location of Care**

Please complete the following.

1. In the past year, have you felt you ought to cut down on your drinking or drug use? ❑ yes ❑ no
2. In the past year, have you had people annoy you by criticizing your drinking or drug use? ❑ yes ❑ no
3. In the past year, have you felt bad or guilty about your drinking or drug use? ❑ yes ❑ no
4. In the past year, have you had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, to get rid of a hangover or to get the day started? ❑ yes ❑ no

Please describe your current use of the following.

Yes *No*

❑ ❑ **Alcohol** _____ times per day / week / month / year *(circle one)*.
How much at a time? _____ When did you first start using it? _____

❑ ❑ **Tobacco**_____ times per day / week / month / year *(circle one)*.
How much at a time? _____ When did you first start using it? _____

❑ ❑ **Caffeine** _____ times per day / week / month / year *(circle one)*.
How much at a time? _____ When did you first start using it? _____

❑ ❑ **Marijuana** _____ times per day / week / month / year *(circle one)*.
How much at a time? _____ When did you first start using it? _____

❑ ❑ **Other: _____,**
_____ times per day / week / month / year *(circle one)*.
How much at a time? _____ When did you first start using it? _____

❑ ❑ **Use of prescription or over-the-counter medicines** _____ times per day / week / month / year *(circle one)*. How much at a time? _____
When did you first start using it? _____

List any problems you have had because of drinking or drug use (with friends, the law, your money, your job, sex, school, family): _____

_____

For therapist only – Do not write in this area:

❑ Therapist discussed general effects of chemical use on health and well-being.

❑ Client given fact sheet discussing general effects of chemicals on health and well-being.

Trauma and abuse history

Describe any major losses you have had (such as death, disability, divorce, relationship changes):

_____

_____

_____

Describe any trauma or abuse in your life (such as physical, sexual or emotional abuse; assault; neglect; domestic violence; witnessing the abuse of another, etc.):

Physical abuse _____

Sexual abuse _____

Emotional abuse _____

Neglect _____

Assault _____

Military-related trauma or distress _____

Discrimination: _____

Other _____

Safety concerns

Have you ever **thought about** hurting or killing yourself, or had an impulse to do so? ❑ yes ❑ no

If yes, do you have a suicide plan? ❑ yes ❑ no

If so, please explain: _____

_____

Have you ever **tried** to hurt or kill yourself? ❑ yes ❑ no

If yes, list the date and method: _____

_____

Have you ever harmed property or other people, or thought about causing harm? ❑ yes ❑ no

If yes, please explain: _____

_____

To your knowledge, are there firearms in your home? ❑ yes ❑ no

If known, how many and of what type (pistol, revolver, rifle, automatic)? _____

_____

Do children or teens have access to these firearms? ❑ yes ❑ no

Are these firearms stored unloaded and locked with trigger guards? ❑ yes ❑ no
(You can get trigger guards free of charge from the local police departments)

Is the ammunition (bullets) kept in a separate location? ❑ yes ❑ no

Medical status (attach another page, if needed)

Do you have a primary care clinic or doctor? ❑ yes ❑ no

Name of clinic or doctor _____

Phone (___)_____ Fax (___)_____

Have you had a physical exam to check for medical reasons for your symptoms? ❑ yes ❑ no

Date of your last physical exam _____

Do you have a psychiatrist? ❑ yes ❑ no

Name of psychiatrist_____

Phone (___)_____ Fax (___)_____ Date of last visit: _____

Have you ever had any major medical problems? ❑ yes ❑ no

If yes, please explain: _____

_____

_____

Do you currently have any physical pain? ❑ yes ❑ no

If yes, please explain: _____

_____

Is your pain constant or chronic (recurring or ongoing)? ❑ yes ❑ no

Please circle your pain level below:

No pain **Mild pain** **Moderate pain** **Severe pain** **Extreme pain** **As bad as it could be**

Are you concerned about your weight or eating habits? ❑ yes ❑ no

Are other people concerned? ❑ yes ❑ no

If yes to either question, please explain: _____

_____

Medication Form

Are you taking any medicines (prescribed or over-the-counter) or herbal products? ❑ yes ❑ no

If yes, please list these below.

	EXAMPLE	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5	Medicine #6
Name of medicine	Celexa						
How many milligrams (mg)?	40 mg						
How many pills do you take at a time?	one						
How many times a day do you take this medicine?	once						
What time of day do you take this medicine?	morning						
What does this medicine treat?	depression						
Name of prescribing doctor	Dr. John Doctor						

If you need more space, please attach another sheet of paper.

Do you have any allergies? ❑ yes ❑ no

Have you ever had a bad reaction to medicine? ❑ yes ❑ no

If yes to either question, please describe: _____

_____

Client signature: _____ **Date:** _____ Time _____

Please check off and explain any symptoms you are having

Symptoms or stressors	When did it start?	How often does it happen?	Therapist notes *(note mild, moderate or severe)*
❑ Compulsive behavior (too much hand washing, checking, TV, spending)			
❑ Grief (job loss, death, health)			
❑ Relationship problems			
❑ Sexual issues (orientation, identity, function)			
❑ Financial issues			
❑ Racing thoughts			
❑ Trouble making decisions			
❑ Impulsive behavior			
❑ Nightmares			
❑ Muscle tension or headaches			
❑ Feeling shaky			

Reviewed by_____ Date _____ Time _____

(Therapist signature and credentials)