Initial Intake Form - Adults

Therapist: ________________________ Today's Date:________________
Patient: ________________________ DOB: __________________

Referral Information

Name of Emergency Contact: ____________________ Phone:_________________________
Who referred you to Quality Life Counseling:_________________________________
Reason for referral? (brief description):____________________________________
Name of Primary Care Physician:______________________Phone:____________________
Address:____Fax:_________________________
Guardian name/address/phone:____
If DHHS involvement, DHHS worker name/address/phone:______________________________

General Behavioral Information

Description of current difficulties/"why now":
If any of the following are concerns for your child, please provide a brief description:

- ☐ Oppositional behavior:
- ☐ Anger/Aggressive behavior:
- ☐ Tantrums:
- ☐ Changes in mood/ interest in activities:
- ☐ Fears/unwanted thoughts:
- ☐ Unusual habits/repetitive behavior:
- ☐ Sleep problems/changes:
- ☐ Appetite problems/changes:
- ☐ Suicidal/homicidal thoughts:
- ☐ Self harming behaviors:
- ☐ Alcohol/drug use
- ☐ Sexual problems
- ☐ Victim of Abuse (sexual/physical)
- ☐ Neglect:
- ☐ Self-esteem:
- ☐ Adjustment (death/divorce/move):
- ☐ Toileting:
- ☐ Attention problems:
- ☐ Hyperactivity:
- ☐ Relationship problems:
- ☐ School problems:

Please describe what you are currently doing to work on these problems:____________________________

Which are most helpful? (example: go for a walk with a dog):____________________________

Patient Background Information/Family History

Patient Name: ________________________________ Nickname: ____________ **DOB**: ____________
Home Address: ________________________________ City: ________________ State: ___ Zip: _____
Phone #: ______________________ May we contact you at this #? Yes_____ No_____
Email:____
Sex (circle): Male / Female
Ethnicity (circle all that apply): African-American Asian-American Hispanic Native American Caucasian Other:______________
Problems with Ethnicity: Yes ____ No____
Religious/Spiritual Community does he/she belong?____
Any practices/rituals that bring comfort? If yes, describe:_____________________________________

Biological parents (complete even if you are an adult) are: married separated divorced never married
*If currently married, how long have they been married?_________

Immediate Family Information
Name of client's spouse/partner/significant other: ____
Please check: Married____ Living Together____ Single____ Separated____ Divorced ____ Widowed____

Other Members of the Household (e*xample: children, foster children, etc*):

Name	DOB/Age	Sex	Relation to patient

Others residing in the home: (*example: parents, siblings, niece/nephew, grandparents, etc*)

Name(s)	Relationship to patient	Describe their relationship

Mother's name:________________________
(circle one) Biological Step Adoptive Foster Other
Home Phone: ___________________________
Work Phone: ___________________________
Highest level of education: ______________
Place of Employment: ___________________
Occupation: ____________________________
Work Schedule:__________________________
Maternal mental health history: ______________

Father's name:________________________________
(circle one) Biological Step Adoptive Foster Other
Home Phone:____________________________________
Work Phone: ____________________________________
Highest level of education: ________________________
Place of Employment: ____________________________
Occupation: _____________________________________
Work Schedule:__________________________________
Paternal mental health history: _____________________

Parents are: Married____ Living Together____ Single____ Separated____ Divorced ____ Widowed____

Siblings (in order, include yourself):

Name	DOB/Age	Sex	Married?

Recent life stressors within last 12 months?
Family death_____ Abuse_____ Change in schools_____ Separation/divorce_____ Marriage_____
Addition to family_____ Family moved_____ Change in job_____ Health problems_____
Family financial problems_____ Any other major/important life event:_______________________________

Academic & Vocational History

Please list each year of graduation to your highest level of education
High School (or highest grade) ____________________________ Year of graduation or GED_______________
Vocational/Trade school (year of graduation) ______________________Trade__________________________
Associates Degree (year of graduation) ____________________________Degree earned___________________
Bachelors Degree (year of graduation) _____________________________Degree earned___________________
Masters Degree (year of graduation) ______________________________Degree earned___________________
Doctorate Degree (year of graduation) _____________________________Degree earned___________________
Other: ____

Job History- Current to Past

Employer	Job Title/Duties	Start/Stop Dates	Reason Quit

Military Experience? Yes_____ No_____ Branch: _____________ Combat Experience? Yes_____ No____
Where: ____
Date drafted/enlisted: ________________________________ Date discharged: ___________________________
Type of discharge: __________________________________ Rank at discharge: _________________________

Medical Information

Medical/Physical Health History (please write anything client has been treated for in the **PAST)**:
____
____

Please list any **CURRENT** health problems/concerns: ____
____
____

Do you have any physical health problems that may interfere with normal functioning (vision, hearing, etc)?
Yes_____ No_____ If yes, please describe: ____
Allergies/adverse drug reactions: Yes_____ No_____ If yes, please describe:_________________________
Last physical:__________________________________ Which physician:______________________________
Describe exercise habits: ____

How much sleep does client typically get?____
Any problems with sleep? None_____ Difficulty falling asleep?_____ Difficulty staying asleep?____
Restless sleeper?_____ Early riser?_____

Does client have problems with appetite? Yes_____ No_____ If yes, please explain:____________________
Overeats_____ Average_____ Under eats_____ Picky eater (describe)_____

Bladder control problems? Yes_____ No_____ If yes, please explain:_______________________________
Bowel control problems? Yes_____ No_____ If yes, please explain:_________________________________

Any PAST Medication(s)	Dose	Frequency	Purpose	Prescribed by
CURRENT Medication(s)	Dose	Frequency	Purpose	Prescribed by

Mental Health History

Previous Counselor(s)	Year(s)	Where	Response/reaction	Issue/Diagnosis
Previous Psychiatric hospitalization(s)	Year	Where	Response/reaction	Issue/Diagnosis
Substance abuse treatment(s)	Year	Where	Response/reaction	Issue/Diagnosis
Self help (SA, NA, AA, Al-Anon, etc)	Year	Where	Response/reaction	Issue/Diagnosis

Trauma History: Has client been the victim of any of the following? **List dates if possible**.

Sexual Abuse_______
Sexual Molestation_______
Emotional/Verbal Abuse_______
Physical Abuse_______
Neglect_______
Domestic Violence_______
Witness Domestic Violence_______

Violent Natural Disaster_______
Life Threatening Accident_______
Witness Life Threatening Accident_______
Financial Scam/Theft_______
Other events where life and safety are threatened

____

Risk Factors: Are you at risk for suicide, homicide, elopement, substance abuse relapse, domestic violence, sexual assaulting, sexual molesting, child abuse, eating disorder, etc? Please explain:

____

____

Patient/Family Legal Concerns & Issues

Are you involved in any active cases (traffic, civil, criminal)? Yes_____ No_____
If yes, please explain specifics:____
Are you presently on probation or parole? Yes_____ No_____
Traffic violations? Yes_____ No_____ If yes, please explain specifics:_________________________________
Other legal history? Yes_____ No_____
Charges (year of charge) Convictions Penalty Sentence Completed?
____
____
____
____
____
____

Family History of Substance Abuse/Dependence (relationship/substance):
____
____

Substance	Y/N	Frequency	Duration	First Use	Last Use
Example	Y	1x a week	2 years	2012	2014
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

*Thank you for providing detailed information regarding your child. This will assist the therapist greatly in understanding your child's and your family's unique needs.

*The information provided on this form is for the purpose of mental/behavioral health evaluation and treatment only. The information provided on this form cannot be released without express written permission of the parent(s) or legal guardian of this child. If you have any questions about how this information will be used, please discuss your concerns with your therapist during your first visit.

I assert that the information provided on this document is true and accurate to the best of my knowledge.

____

Client/Guardian Print and Signature ***Date***

____

Witness Print and Signature ***Date***