351 Wagoner Drive Suite 135
Fayetteville, NC 28303

Confidential ADULT Individual Intake Form

Contact Information

Name: _____ Date: _____

Sex: ___ Male ___ Female Height: _____ ' _____ "" Weight: _____

SS#: _____ _____ _____ Age: _____ DOB: _____

Address: _____ _____ _____ _____
Street Address City State Zip

Phone: _____ _____ _____
Home Business Cell

Emergency Contact Information

Emergency Contact Person: _____ _____
Name Relationship to you

Emergency Contact's Phone: _____ _____ _____
Home Business Cell

Employment Information

Employer: _____ Occupation/Title: _____

Employer Information: _____ _____
Address Phone

Hours per week: _____ Years at job: _____ Highest level of education completed: _____

Education ____ Some High School ____ Some College ____ Graduate School

____ High School Graduate/GED ____ College Graduate ____ Degrees Held _____

Cultural/Religious Information

Race: _____ Caucasian _____ African-American ___ Hispanic ___ Native American

_

___ Asian ___ Other _____

Cultural heritage (i.e., Italian, Scottish, Argentinean): _____

Do you regularly attend a church, synagogue or other religious institution? _____ Yes _____ No

Member? _____ Yes _____ No

Name of church/institution: _____

Name of pastor: _____

Relational Information

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

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse: _____ Spouse's age: _____

Spouse's Occupation: _____

Please provide a brief description of your spouse's characteristics (e.g., angry, controlling, outgoing, supportive):

_____

_____

Please list your children, including step, adopted and foster children (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

_____ Physical Abuse _____ Emotional Abuse ___ Sexual Abuse ___ Abortions

_____ Gambling _____ Drug/Alcohol Addiction ___ Religious Upbringing ___ Major Losses

_____ Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

_____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? _____ Yes _____ No

If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? _____ Yes _____ No

If yes, who and when: _____

Medical History

Name and Town of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues and Goals

Circle any of the flowing symptoms or problems that you are currently or have recently experienced:

____ Stress	____ Grief	____ Verbal abuse	____ Impulsive behavior
____ Anxiety	____ Chronic pain	____ Sexual abuse	____ Controlling
____ Sexual problems	____ Fears	____ Loneliness	____ Sexual addiction
____ Obsessive thoughts	____ Depression	____ Panic	____ Compulsive behavior
____ Poor concentration	____ Shyness	____ Gender identity	____ Anger
____ Fatigue	____ Low self-esteem	____ Hearing voices	____ Loss of appetite
____ Bad dreams	____ Marital problems	____ Aggression	____ Racing thoughts
____ Trouble sleeping	____ Apathy	____ Relational issues	____ Eating problems
____ Physical Abuse	____ Unwanted memories	____ Alcohol use	____ Feeling worthless
____ Emotional Abuse	____ Loss of control	____ Pregnancy/Abortion	____ Work issues
____ Financial issues	____ Controlled by others	____ Drug use	____ Career choices
____ Loss	____ Indecisiveness	____ Spiritual apathy	____ Seeing/Hearing things others don't

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

Please place an **X** on the scale below to indicate how distressing your problems are to you.

___ Very minimal distress ___ Moderate distress ___ Very extreme distress

Are you currently experiencing any suicidal thoughts? _____ Yes _____ No
Have you experienced suicidal thoughts or attempted suicide in the past? _____ Yes _____ No
Are you currently experiencing any violent or homicidal thoughts? _____ Yes _____ No

Please describe any of the following:

_____

_____

_____

_____

Referral Information

How did you find us (referred by doctor, friend, family, internet, EAP or other)? _____

_____