anathallo COUNSELING

Adult Intake Form

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____ County: _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell/Work/Other Phone: _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we leave a message? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Date of current marriage _____ Spouse's Name _____ Date of birth _____

Have you ever been separated from your present spouse? ☐ Yes ☐ No

Children:

Name	Relationship (son, step-son, etc.)	Living at Home (yes/no)	Age	Marital Status

_____

Your previous marriage (if applicable)

Date	Children from this marriage
_____to_____	_____
_____to_____	_____

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner:

Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list:

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list and provide dates:

General and Mental Health Information

11. How would you rate your current physical health? (Please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks, or phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Check		List Family Member
Alcohol/Substance Abuse	☐ yes	☐ no	_____
Anxiety	☐ yes	☐ no	_____
Depression	☐ yes	☐ no	_____
Domestic Violence	☐ yes	☐ no	_____
Eating Disorders	☐ yes	☐ no	_____
Obesity	☐ yes	☐ no	_____
Obsessive Compulsive Behavior	☐ yes	☐ no	_____

Schizophrenia	☐ yes	☐ no	_____
Suicide Attempts	☐ yes	☐ no	_____

Additional Information

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?