SAINT LOUIS COUNSELING

# Intake Forms – Adult

PRESENTING PROBLEM

Please tell us why you are seeking services at this time._____

_____

_____

What do you hope to accomplish from the services you receive?_____

_____

SYMPTOM CHECKLIST – Please check all that apply.

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| | | Addictions | | | Hopelessness |
| | | Aggressive behavior | | | Hyperactivity |
| | | Anger | | | Impulsivity |
| | | Anxiety/worry | | | Isolation |
| | | Appetite changes | | | Lack of motivation |
| | | Breaking the law | | | Learning problems |
| | | Crying spells | | | Loss/death of a significant person |
| | | Decreased energy | | | Marital/relationship problems |
| | | Depression | | | Mood swings |
| | | Developmental disabilities | | | Physical complaints |
| | | Difficulty concentrating | | | School problems |
| | | Disobedience | | | Self-mutilation |
| | | Drugs/alcohol | | | Sexual problems |
| | | Eating disorders | | | Sleep changes |
| | | Fears | | | Speech/language problems |
| | | Fighting | | | Stress |
| | | Fire setting | | | Suicidal thoughts |
| | | Hallucinations | | | Temper tantrums |
| | | Health problems | | | Wets bed |
| | | Homicidal thoughts | | | Other: |

FAMILY AND SOCIAL INFORMATION

Please list family members and others who are living at your address.

| Name | Relationship | Age |
|---|---|---|
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Please list any of your children who are not living at your address.

| Name | Relationship | Age |
|---|---|---|
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Date of Present Marriage_____ Date of Separation, if applicable_____
Date of Previous Marriage_____ Date of Separation/Divorce_____
Date of Previous Marriage_____ Date of Separation/Divorce_____

Please list your family members, including biological and step family members.

| Family Member | Name | Age | Marital Status | If deceased, date and cause |
|---|---|---|---|---|
| Parent | | | | |
| Parent | | | | |
| Parent | | | | |
| Parent | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |

How would describe your relationship with your mother?_____

How would you describe your relationship with your father?_____

Have you or any family members been physically, emotionally, or sexually abused? If yes, please describe._____

_____

_____

Have you ever been a perpetrator of abuse? If yes, please describe._____

_____

Is spirituality/religion a part of your life? If yes, please describe._____

_____

Who are your main social supports?_____

EDUCATION INFORMATION

Were you ever diagnosed with a learning or conduct disorder while in school? If yes, please describe._____

_____

Were you ever bullied in school? If yes, please describe._____

EMPLOYMENT INFORMATION

How long have you been employed in your present job?_____Length of longest employment_____

What types of jobs have you previously held?_____

Are you under work/financial stress? If yes, please describe._____

LEGAL INFORMATION

Have you ever been arrested? If yes, please describe._____

_____

Are you currently on probation or parole? If yes, please describe._____

_____

Are you currently involved in any legal actions, such as divorce, bankruptcy, or lawsuit? If yes, please describe._____

_____

Have you ever received a DWI or DUI? If yes, please describe._____

## SUBSTANCE ABUSE INFORMATION

Do you smoke or use tobacco? If yes, how much and how often?_____

How many times a week do you drink alcohol?_____How many drinks do you usually consume during each occurrence?_____

Have you ever felt the need to cut down on your drinking? ____Yes ____No
Have you ever become annoyed at criticism about your drinking ____Yes ____No
Do you ever feel guilty about your drinking? ____Yes ____No
Do you ever need a drink in the morning to get going? ____Yes ____No

Do you or any family members have a history of alcohol and/or drug abuse/dependency? If yes, please describe._____

_____

## MEDICAL INFORMATION

Primary Care Doctor_____Phone #_____Last Exam Date_____

Please list any current and past impairments, illnesses, surgeries, and hospitalizations._____

_____

_____

Allergies_____

How frequently do you exercise?_____

Current Medications

| Name of Medication | Dosage | Frequency | Taken As Prescribed? | Date Started | Prescribing Physician | List Any Side-Effects |
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Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

| Individual Receiving Treatment | Type of Treatment (i.e., outpatient, inpatient, residential, chemical dependency, etc.) | Service Provider | Dates |
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## STRENGTHS

Please list some of your strengths and positive qualities._____

_____

What hobbies and interests do you enjoy?_____

_____

Is there anything else you would like us to know?_____

_____