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

Please list any of your children who are not living at your address.

Name	Relationship	Age

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				

FAMILY AND SOCIAL INFORMATION (CONTINUED)

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.

Please list any allergies.

How frequently do you exercise?

Pre-existing Medical Conditions

Please check all that apply.

Past	Present		Past	Present	
		Hypertension			Malaise and Fatigue
		Hyperlipidemia			Joint Pain
		Diabetes			Acute Laryngopharyngitis
		Back Pain			Acute Maxillary Sinusitis
		Anxiety			Major Depressive Disorder
		Obesity			Acute Bronchitis
		Allergic Rhinitis			Asthma
		Reflux Esophagitis			Depressive Disorder
		Respiratory Problems			Nail Fungus
		Hypothyroidism			Coronary Atherosclerosis
		Visual Refractive Errors			Urinary Tract Infection
		Osteoarthritis			Head Injury
		Fibromyalgia/myositis			Falls/Falling
		Headaches			Parkinson's Disease
		Other:			

Current Medications

Name of Medication	Dosage	Frequency	Taken As Prescribed?	Date Started	Prescribing Physician	Side-Effects

Please indicate any recent changes in the child's medication (i.e. changes in dosage/frequency, changing side effects, recently discontinued medications, etc.).

BEHAVIORAL HEALTH INFORMATION

Please answer the following questions regarding your behavior health history.

Have you received counseling before?

Have you received a mental health diagnosis? If yes, please indicate.

What did you find helpful about previous counseling?

Have you ever been hospitalized? If so, please indicate date(s) and reason for hospitalization.

Do you have a history of self-injury/suicidal ideation? If yes, please indicate the most recent incident.

Have your behavioral health concerns impacted your performance at work/school, or your relationships with family/friends? If yes, please explain.

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**

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?