# Glad Heart Counseling & Equipping Center PLLC

## Adult Intake Form

Date _________ Referred by____________

**General Information**

Name (Last, First) ____________________________________________ Gender Male __ Female ___

Date of birth _______________________ Age__________ Ethnicity _____________________

Home address ________________________________________________________________________

Phone number (Permission to leave message: Yes No)

Home _____________(Yes No) Cell _______________(Yes No) Work _____________(Yes No)

Email address _______________________________________________________________________

Occupation_______________________ Employer __________________________________________

Education level ________________________ Religious affiliation ___________________________

In case of an emergency, contact:

Name ________________________ Relationship _____________________ Phone _________________

**Family History/Experiences**

Current living arrangements:

Family of origin___ Relatives___ Single ___
Married___ Roommate(s)___ Single parent w/children___
Married w/children___ Significant other___ Other______________

Marital Status (indicate all that apply and duration of each, ex. 1989-2011): Never married_________
Married 1__________ Separated 1__________ Divorced 1__________ Widowed 1__________
Married 2__________ Separated 2__________ Divorced 2__________ Widowed 2__________
Married 3__________ Separated 3__________ Divorced 3__________ Widowed 3__________

If divorced, describe your relationship with your ex-spouse ______________________________________
_____________________________________________________________________________________

Present Family

| Name | Age | Gender | Relationship to you (include step, half, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Family of Origin Primary Household (Family in which you resided the majority of your life)
List your family members, by household, beginning with the oldest member

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Name ___________________ Age _____ Gender __________ Relationship to you (include step, half, etc.) ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________

Family of Origin Second Household (if applicable)

Name ___________________ Age _____ Gender __________ Relationship to you (include step, half, etc.) ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________
___________________ _____ __________ ____________________

Mother's Marital Status (indicate all that apply):

Never married__________ Married___________ Remarried___________
Divorced___________ Separated___________ Widowed____________
Number of Marriages_____

Father's Marital Status (indicate all that apply):

Never married__________ Married___________ Remarried___________
Divorced___________ Separated___________ Widowed____________
Number of Marriages_____

History of psychiatric illness in your family? ______________________________________________

________________________________________________________________________

History of physical, emotional, or sexual abuse in your family? ______________________________

________________________________________________________________________

History of alcohol or drug abuse in your family? ___________________________________________

________________________________________________________________________

History of family violence or criminal activity in your family?______________________________

________________________________________________________________________

**Health**

Primary Care Physician ___________________________________________________________

Have you ever been hospitalized for mental health concerns? Yes __ No __

If yes, When? __________Why?_______________________________________________________

Describe any medical concerns ______________________________________________________

________________________________________________________________________

Have you ever seen a mental health professional (counselor, psychologist, psychiatrist)?

Yes __No __ (If so, I will need your permission in order to communicate with that individual or agency)

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Previous mental health professional/agency ___________________________________________

Reason for mental health service___________________________________________________

Phone __________________ Dates of service (beginning-ending) ______________________________

Check the following items for a diagnosis or medication that you are now receiving or has received:

| Diagnosis | Current (List dates) | Past (List dates) | Physician's Name | Name of medication | Dosage |
|---|---|---|---|---|---|
| Depression | _______ | __________ | _______________ | ________________ | _____ |
| ADHD | _______ | __________ | _______________ | ________________ | _____ |
| ADD | _______ | __________ | _______________ | ________________ | _____ |
| Learning Disability | _______ | __________ | _______________ | ________________ | _____ |
| Anxiety/ Nervousness | _______ | __________ | _______________ | ________________ | _____ |
| Panic Attack | _______ | __________ | _______________ | ________________ | _____ |
| Manic-Depression (Bipolar) | _______ | __________ | _______________ | ________________ | _____ |
| Schizophrenia | _______ | __________ | _______________ | ________________ | _____ |
| Mood/Anger | _______ | __________ | _______________ | ________________ | _____ |
| Tics | _______ | __________ | _______________ | ________________ | _____ |
| Insomnia/ Sleeplessness | _______ | __________ | _______________ | ________________ | _____ |
| Obsessive/ Compulsive | _______ | __________ | _______________ | ________________ | _____ |
| Addictions | _______ | __________ | _______________ | ________________ | _____ |
| Convulsions | _______ | __________ | _______________ | ________________ | _____ |
| Other | _______ | __________ | _______________ | ________________ | _____ |

What other medication are you currently taking?

| Medication | Dosage | Taken for what reason? |
|---|---|---|
| ______________________________ | ________________ | ___________________________ |
| ______________________________ | ________________ | ___________________________ |
| ______________________________ | ________________ | ___________________________ |

**Current Concerns**

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Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue)

___Abuse (physical, emotional, sexual)
___Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
___ADD, ADHD symptoms
___Career dissatisfaction or decisions
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Family or Step-family relationship
___Feeling angry or irritable
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling guilty or shameful
___Feeling sadness or depression or suicidal urges NOT related to grief
___Feeling sadness or depression or suicidal urges related to grief
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (repeated run-ins with the law, etc.)
___Learning/Academic difficulties
___Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Personal Growth (no specific problem)
___Religious or Spiritual concerns
___Sexual functioning concerns
___Sexual identity concern
___Significant other/spouse relationship
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Other: Explain_______________________________________________________________

Further describe of above or any other concerns:

________________________________________________________________________

________________________________________________________________________

When did you first become concerned about this issue? ___________________________________

How have you attempted before now to deal with this issue? ______________________________

________________________________________________________________________

Other treatment you have received to address any of the concerns indicated above: None_______

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| | | |
|---|---|---|
| Couples Counseling___ | Group counseling___ | Individual counseling______ |
| Family counseling___ | Hospitalization _____ | Other ___________________ |