Intake Form/ Personal History (18+)

Client's name: ____ Date of Birth:____________________________

Gender: ____ Age: ____

Form completed by (if someone other than client): ____

Marital Status ____________________________________Sexual Orientation __________________________________
Assessment of current relationship _______Good _______Fair _______ Poor _______N/A

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? ____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: ____
____

Other cultural/ethnic information: ____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: ____

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: ____

PRIMARY REASON(S) FOR SEEKING SERVICES

____

____

Please check behaviors and symptoms that occur to you **more often than you would like** them to take place:

Symptoms	Onset	Duration	Frequency
Addictive behaviors ☐			
Aggression/ Anger ☐			
Alcohol/ Drug Dependence ☐			
Antisocial behavior☐			
Anxiety ☐			
Avoiding people ☐			

Symptoms	Onset	Duration	Frequency
Chest pain ☐			
Coping☐			
Cyber addiction ☐			
Depression ☐			
Disorganized thoughts☐			
Disorientation ☐			
Distractibility ☐			
Dizziness☐			
Drug dependence ☐			
Eating disorder ☐			
Elevated mood☐			
Fatigue☐			
Fears/ Phobias☐			
Gambling ☐			
Hallucination ☐			
Heart palpitations ☐			
High blood pressure ☐			
Hopelessness☐			
Impulsivity ☐			
Irritability ☐			
Judgment errors ☐			
Loneliness ☐			
Memory impairment☐			
Mental confusion ☐			
Mood shifts ☐			

Symptoms	Onset	Duration	Frequency
Panic attacks ☐			
Recurring thoughts ☐			
Sexual addiction ☐			
Sexual difficulties ☐			
Sick often ☐			
Sleeping problems ☐			
Speech problems ☐			
Suicidal thoughts ☐			
Trembling ☐			
Withdrawing ☐			
Worrying ☐			

Briefly discuss how the above symptoms impair your ability to function effectively: ____

____
____
____
____
____
____
____
____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, describe: ____

____
____
____

___ Other mental health concerns (specify): ____

COUNSELING /TREATMENT HISTORY

Information about **client** (past and present) When/Where Your reaction to overall experience
____

Counseling/psychiatric treatment ____

Suicidal thoughts/attempts ____

Drug/alcohol treatment ____

Hospitalizations ____

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) ____

MEDICAL/PHYSICAL HEALTH

List any current health concerns: ____

List any recent health or physical changes: ____

-

____

____ AIDS
____ Alcoholism
____ Abdominal pain
____ Abortion
____ Allergies
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bronchitis
____ Bed-wetting
____ Cancer
____ Chest pain
____ Chronic pain
____ Colds/Coughs
____ Constipation
____ Chicken pox
____ Dental problems
____ Diabetes
____ Diarrhea
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Miscarriages
____ Neurological disorders
____ Nausea
____ Nose bleeds
____ Pneumonia
____ Rheumatic fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet fever
____ Sinusitis
____ Smallpox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting
____ Whooping cough
____ Other (describe):

Nutrition

____

Breakfast______ /week Lunch_______ /week Lunch_______ /week Snacks_____ /week

Comments on

quality:____

Current Medication	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes ____ No

If yes, describe:

____

____

____

Family history of medical problems: ____

____

SUBSTANCE/ CHEMICAL QUESTIONS

Substance of preference

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

Describe when and where you typically use substances:

____

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use): ____________________

____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): ______________________________

How do you believe your substance use affects your life? ______________________________

Who or what has helped you in stopping or limiting your use? ______________________________

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: ______________________________

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): ______________________________

____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe:____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe:____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	____________	______	______	______	____	____	____	____
Barbiturates	____________	______	______	______	____	____	____	____
Valium/Librium	____________	______	______	______	____	____	____	____
Cocaine/Crack	____________	______	______	______	____	____	____	____
Heroin /Opiates	____________	______	______	______	____	____	____	____
Marijuana	____________	______	______	______	____	____	____	____
PCP/LSD/Mescaline	____________	______	______	______	____	____	____	____
Inhalants	____________	______	______	______	____	____	____	____

Caffeine	______	______	______	______	____	____	____	____
Nicotine	______	______	______	______	____	____	____	____
Over the counter	______	______	______	______	____	____	____	____
Prescription drugs	______	______	______	______	____	____	____	____
Other drugs	______	______	______	______	____	____	____	____

FAMILY INFORMATION

PARENTAL INFORMATION

____ Parents legally married ____ Mother remarried: Number of times: ________

____ Parents separated ____ Father remarried: Number of times: ________

____ Parents divorced ____Single parent

____Raised by Grandparents

Relationship	First Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	______	______	____	____	____	____
Father	______	______	____	____	____	____
Spouse	______	______	____	____	____	____
Children	______	______	____	____	____	____
	______	______	____	____	____	____
	______	______	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)

Relationship	First Name	Age	Living Yes	No	Living with you Yes	No
______	______	______	____	____	____	____
______	______	______	____	____	____	____
______	______	______	____	____	____	____
______	______	______	____	____	____	____
______	______	______	____	____	____	____
______	______	______	____	____	____	____

Special circumstances (e.g., raised by person other than parents, information about step sibling etc.): ______________________

Information **about family/significant others** (past and present):____

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	______	______	______
Suicidal thoughts/attempts	____	____	______	______	______
Drug/alcohol treatment	____	____	______	______	______
Hospitalizations	____	____	______	______	______
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	______	______	______

MORE ABOUT YOU

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): ______________________________

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: ______________________________

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): ____________

Comments re: childhood development: ______________________________

____

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED

____ Vocational: Number of years: ______ Graduated: ______ Yes ______ No Major: ____________
____ College: Number of years: ______ Graduated: ______ Yes ______ No Major: ____________
____ Graduate: Number of years: ______ Graduated: ______ Yes ______ No Major: ____________

Other training:______________________________

Special circumstances (e.g., learning disabilities, gifted):______________________________

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Type of Work	Dates	Title	Reason left the job

____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): ____________

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No

Where: ____

Branch: ______________________________ Discharge date: ________________________

Date drafted: ____________________________ Type of discharge: ______________________

Date enlisted: _______________ Rank at discharge: ___________________

Legal History

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe: ____

____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: ____

Past History

Traffic violations: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No
DWI, DUI, etc.: ____ Yes ____ No
Civil involvement: ____ Yes ____ No

If you responded Yes please describe:____

____

What are some of your strengths ____

____

____

What are some of your limitations ____

____

____

What are your goals for therapy? ____

____

____

____

Client Signature:____ Date: ____/____/______

For Staff Use

Therapist's signature: ____ Date: ____/____/______

Supervisor's comments:____

____

____

Supervisor's signature/credentials: ______________________________________ Date: ___/___/______
(Certifies case assignment, level of care and need for exam)