

Grace Point Counseling Center
Adult
Intake Information

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

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

Primary reason(s) for seeking services:

Marital Problems Parenting Relationship Family
 Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive behaviors Alcohol/drugs Eating Habits
 Job Medical / Health problems
 Other mental health concerns (specify): _____

*If you need any more space for any of the questions please use the back of the sheet.

Marital Status

(more than one answer may apply)

Single Divorce in process Unmarried, living together
Length of time: _____ Length of time: _____
 Legally married Separated Divorced
Length of time: _____ Length of time: _____ Length of time: _____
 Widowed Annulment
Length of time: _____ Length of time: _____ Total number of marriages: _____

Religious/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: _____

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

If Yes, describe: _____

Do you have a religious affiliation? ___ Yes ___ No

If Yes, please explain: _____

Legal

Are you involved in any criminal proceedings or litigation at the present time? ___ Yes ___ No

If Yes, please describe: _____

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

If Yes, please describe: _____

Education

Level of education completed: GED High School Some College
 Associate Bachelors Masters PhD Other
Ex: _____

Currently enrolled in school? Yes No

If Yes, where: _____

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

Military

Military experience? Yes No Combat experience? Yes No

Where: _____

Branch: _____ Discharge date: _____

Type of discharge: _____

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical/Physical Health

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Bladder control | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriages | |

Other (describe): _____

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Length of Time	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Length of Time	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:
 Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight Nervousness/tension
 Describe changes in areas in which you checked above: _____

Please tell us about your prior counseling and/or treatment history:

	Yes	No	When	Where	Reason / Diagnosis
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Have any of your family members or significant others had counseling or treatment in any of the above areas?

Do you drink alcohol? Yes No If so, how often and in what quantity? _____

Have you used/abused drugs, alcohol or controlled substances? Yes No If yes, please explain:

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 drugs or alcohol created a problem for your job/relationship? ___ Yes ___ No

If Yes, describe: _____

Behavioral History

Please check behaviors and symptoms that are problematic for you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Phobias/fears | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Disruptive thoughts |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual addiction | <input type="checkbox"/> Spending problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Social problems |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Other (specify): _____ |

Briefly discuss how the above symptoms impact your ability to function: _____

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

___ Yes ___ No If Yes, please explain:

Stress Indicators

Were there special, unusual, or traumatic circumstances that affected you in childhood? ___ Yes ___ No

(i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)

If Yes, please describe:

Please check any events that have occurred in the last 12 months:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Moving | <input type="checkbox"/> Divorce | <input type="checkbox"/> Financial Problems |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Car trouble | <input type="checkbox"/> Birth of a child |
| <input type="checkbox"/> Natural disaster | <input type="checkbox"/> Job Change | <input type="checkbox"/> Death of a close family member/friend |