GRACEPOINT
COUNSELING CENTER

ADULT INTAKE INFORMATION FORM

We are honored that you have selected Grace Point Counseling Center (GPCC) to provide counseling services. All of us wish to do our best to assist you in making this experience meaningful.

Please read all of the pages thoroughly and let us know if you have any questions regarding their content.

Please complete the information inside.

ADULT INTAKE INFORMATION FORM

Client Name: _____ Date: _____

Gender: Female _____ Male _____ Date of Birth: _____ Age: _____

SSN: _____ DL: _____

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

Primary reason(s) for seeking services (Please check the following that applies):

_____ 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)
_____
_____
_____

Marital Status: (More than one answer may apply)

_____ Single
_____ Legally Married
Length of Time: _____
_____ Widowed
Length of Time: _____
_____ Divorce in Process
Length of Time: _____
_____ Separated
Length of Time: _____
_____ Annulment
Length of Time: _____
_____ Unmarried, Living Together
Length of Time: _____
_____ Divorced
Length of Time: _____
Total Number of Marriages:
_____

Religious/Cultural/Ethnic:

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

If yes, to which cultural or ethnic group do you belong?: _____

Please describe the issue: _____

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, describe: _____

Legal:

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

If yes, describe: _____

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

If yes, describe: _____

Education:

Level of education completed:

____ GED	____ Associate	____ Doctorate
____ High School	____ Bachelor's	____ Other:
____ Some College	____ Master's	_____

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
Mother	_____	_____	Yes _____ No _____	Yes _____ No _____
Father	_____	_____	Yes _____ No _____	Yes _____ No _____
Spouse	_____	_____	Yes _____ No _____	Yes _____ No _____
Children (1)	_____	_____	Yes _____ No _____	Yes _____ No _____
Children (2)	_____	_____	Yes _____ No _____	Yes _____ No _____
Children (3)	_____	_____	Yes _____ No _____	Yes _____ No _____

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

_____	_____	Yes _____ No _____	Yes _____ No _____
_____	_____	Yes _____ No _____	Yes _____ No _____
_____	_____	Yes _____ No _____	Yes _____ No _____
_____	_____	Yes _____ No _____	Yes _____ No _____

Medical/Physical Health: (Please check the following that applies):

_____ AIDS
_____ Alcoholism
_____ Abortion
_____ Anemia
_____ Bladder Control
_____ Cancer
_____ Chronic Pain
_____ Dizziness
_____ Diabetes
_____ Drug Abuse
_____ Epilepsy
_____ Eating Problems
_____ Fatigue
_____ Hepatitis
_____ Headaches/Migraines
_____ High Blood Pressure
_____ Mononucleosis
_____ Miscarriages
_____ Nausea
_____ Neurological Disorders
_____ Sexual Problems
_____ Sleeping Disorders
_____ Stomach Aches
_____ Sexually Transmitted Diseases
_____ Thyroid Problems
_____ Vomiting

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:

Family Information:	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 yes, 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 have/had a problem with drugs or alcohol? Yes _____ No _____

If yes, please 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:

_____ Aggression	_____ Phobias/Fears	_____ Pornography
_____ Alcohol Dependence	_____ Fatigue	_____ Disruptive Thoughts
_____ Anger	_____ Gambling	_____ Spending Problems
_____ Anemia	_____ Sexual Addiction	_____ Sexual Difficulties
_____ Hallucinations	_____ Heart Palpitations	_____ Sleeping Problems
_____ Anxiety	_____ High Blood Pressure	_____ Speech Problems
_____ Avoiding People	_____ Hopelessness	_____ Suicidal Thoughts
_____ Chest Pain	_____ Impulsivity	_____ Disorganized Thoughts
_____ Cyber Addiction	_____ Irritability	_____ Trembling
_____ Depression	_____ Judgment Errors	_____ Withdrawing
_____ Disorientation	_____ Loneliness	_____ Worrying
_____ Distractibility	_____ Memory Impairment	_____ Social Problems
_____ Dizziness	_____ Mood Shifts	_____ Other (Specify):
_____ Drug Dependence	_____ Hyperactivity	_____
_____ Eating Disorder	_____ Panic Attacks	_____

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, describe: _____

_____

_____

Stress Indicators:

Were there special, unusual, or traumatic circumstances that affected you in childhood? (i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss) Yes _____ No _____

If yes, please describe: _____

_____

_____

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

_____ Moving
_____ Marriage
_____ Natural Disaster
_____ Divorce
_____ Car Trouble
_____ Job Change
_____ Financial Problems
_____ Birth of a Child
_____ Death of a Close Family Member/Friend

COUNSELING GOALS

What would you like to see accomplished in your counseling?

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____