Monument
Christian Counseling LLC

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ADULT INTAKE FORM

Date: _____

Client Name: _____

Address: _____ City: _____ Zip: _____

Cell/Home: _____ Work: _____ Email: _____

Age: _____ DOB: _____ SS# _____ Religious Affiliation: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Never married ☐ Married ☐ Single ☐ Divorced ☐ Remarried ☐ Widow(er)

Name of Spouse: _____

(if married)

Marital History

1st Marriage: Date _____ Spouse _____ Children and Ages _____

2nd Marriage: Date _____ Spouse _____ Children and Ages_____

3rd Marriage: Date _____ Spouse _____ Children and Ages _____

Who has custody of your minor children: _____

What brings you to counseling at this time? _____

_____

_____

What are your goals for therapy? (i.e., if therapy is successful, what are you hoping will be different about your life?) _____

_____

_____

What are your strengths that will assist you in reaching your goals? _____

_____

Have you ever been to counseling before? ☐ Yes ☐ No If yes, when? _____

Give a brief description of issues worked on: _____

_____

List any significant health problems: _____

_____

Are you currently taking prescription medications? ☐ Yes ☐ No

Medication	Dosage	Medication	Dosage

SELF HISTORY

Do you currently use drugs or alcohol? ☐ Yes ☐ No If yes, how often? _____

Have you ever been in a drug, alcohol or other treatment program? ☐ Yes ☐ No (if you are comfortable, briefly describe.) _____

_____

Have you ever engaged in self harm? ☐ Yes ☐ No If yes, list methods _____

_____

Have you ever thought about completing suicide? ☐ Yes ☐ No (if you are comfortable, briefly describe.)

_____

_____

What kind of support system do you have? _____

What are your interests and hobbies? _____

_____

Has there been a death of someone close?

Relationship	When	Relationship	When

Child Abuse? ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

Sexual Assault/Rape? ☐ Yes ☐ No

Please check any current or past issues:

☐ Family	☐ Health	☐ Career choices	☐ Parenting
☐ My past	☐ Dating	☐ Stress	☐ Eating disorder
☐ Parents	☐ Marriage	☐ Sexual problems	☐ Finances
☐ Spiritual concerns	☐ Legal issues	☐ Grief	☐ Work
☐ Assertiveness	☐ Suicidal thoughts	☐ Violence	☐ Separation/Divorce

Other areas: _____

_____

If you currently experience any of the following symptoms, please rate them using the key below:

0 = Never **1 = Sometimes** **2 = Often** **3 = Always**

Difficulty concentrating _____	Lying to others _____	Panic attacks _____
Crying _____	Feeling out of control _____	Obsessiveness _____
Missing work _____	Feeling self-doubt _____	Anger _____
Feeling uptight/edgy _____	Memory loss or blackout _____	Guilty feelings _____
High energy level _____	Feeling hopeless _____	Nightmares _____
Difficulty sleeping _____	Withdrawing socially _____	Feeling afraid _____
Low energy level _____	Hearing voices _____	Worrying _____

Physical symptoms (e.g., headaches, digestive, muscle tension) _____

_____

_____

FAMILY HISTORY

In your family, is there a history of:

☐ Mental illness	☐ Sexual abuse
☐ Substance abuse	☐ Physical abuse
☐ Divorce	☐ Neglect
☐ Alcoholism	☐ Suicide/Suicidal attempt
☐ Domestic violence	☐ Custody issues

Would you like a receipt of service for health insurance to be reimbursed for session fees? ☐ Yes ☐ No

How were you referred to this office? Please check the best answer:

Online: ☐ Website ☐ Online directory ☐ Theravive.com ☐ Psychology Today

Other: _____

Phone Book: ☐ Mesa County Phone Book ☐ Yellow Pages Phone Book

☐ **TV** or ☐ **Newspaper**

Other: _____