

Adult Counseling Intake Form 2

Name: _____ DoB: _____ dd / mm / yyyy

Age: _____

Sex

Male Female Non-binary

Marital Status

- Single
- Married
- Divorced
- Cohabiting
- Divorce in process
- Separated
- Widowed

Length of current marriage/relationship: _____ How many times have you been married: _____

Rate your current relationship, if applicable

Poor Fair Go

Years of education completed: _____

Currently enrolled in High School/GED

Yes No

College

Yes No

Vocational

Yes No

Graduate School

Yes No

Other training

Yes No

If yes, what training: _____

Any Special Circumstances regarding education

Military experience

Yes No

Combat experience

Yes No

Where: _____ Branch: _____

Length of service: _____ Type of Discharge: _____

Rank at discharge: _____ Current employment/job title: _____

Employment history

Level of job satisfaction (1-5): Why

Gaps in employment history (if any)

Reasons for leaving your work (if applicable)

What activities do you enjoy and feel you are successful when you try

What personal qualities do you think you have

What personal qualities would others say you have

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? Be as descriptive as you can

Have you experienced any traumatic events or significant losses? If so, tick what you think applies to you and indicate anything that's not included in the list

- | | |
|--|---|
| <input type="checkbox"/> Abduction | <input type="checkbox"/> Cultural |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Hate crime |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Medical/Physical |
| <input type="checkbox"/> Torture/War | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Criminal | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Identity theft | <input type="checkbox"/> Loss of culture |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Witness of torture |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Deaths |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Internet Fraud |
| <input type="checkbox"/> Loss of independence | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Work Related/Job Loss | |

What words would you use to describe your family

Are you aware of any birth trauma your mom had during her pregnancy with you, or from age 0-3? Yes or No? If yes, what did she think of it

Did they experience any abuse as a child, whether at home or outside (physical, verbal, emotional, or sexual)? Please describe as much as you feel comfortable

Do you experience abuse in your adult life? Please describe as much as you feel comfortable

Did you get the support that you needed from your family or friends

Have you previously seen a counselor

- Yes No

If yes, where: _____ Approximate Dates of Counseling: _____

For what reason did you go to counseling

Do you have a previous mental health diagnosis: _____

Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started

Yes No

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past

How did these issues affect you and your loved ones, or how are they affecting you now

How would you describe yourself when it comes to your emotions

Have you ever had thoughts about self-harm or harming others

Have you enacted those thoughts? If so, why

Would you happen to have a support system? If so, who comprises this system

Have you ever experienced hospitalization/treatment for psychiatric problems

Would you happen to have any memory and cognitive problems

What significant problems or stresses are you facing at the present time

Is there any specific belief system that we counselors/therapists need to be aware of

Did religion/spiritual practice play a part in your upbringing

Briefly describe the problem for which you are seeking to have counseling/therapy for

When do you think these problems/symptoms first occurred

What is most concerning for you right now

What is most concerning for your family and friends regarding you right now that you are aware of

What would you like to see happen as a result of counseling/therapy

Anything else you'd like to share

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I, _____, understand the above and have thoroughly read the Notice of Privacy Practices: _____

Signature