

The Gentle Shepherd Counseling Center
Adult Intake and History Form

NAME _____ AGE _____ DOB _____ DATE _____

CURRENT PSYCHOLOGICAL STATUS

What are you seeking help with? _____

Has anything been worrying or bothering you? Yes No _____

Any problems with depression? Yes No

With your temper, do you have a, Short Fuse Medium Fuse Long Fuse

Any problems with your thinking, memory, concentration? Yes No

Have you ever seen a counselor, psychologist, or psychiatrist? Yes No If yes, who?

Have you ever had a "nervous breakdown"? Yes No

Ever hospitalized for your nerves or emotional problems? Yes No

Anyone in your family have emotional problems? Yes No

Any past or current suicidal thoughts or attempts? Yes No

DEMOGRAPHIC INFORMATION

Are you: Single Married Divorced Widowed Re-married

If married, is your marriage, Good Fair Poor Very Poor

Have you ever been separated or divorced? Yes No

If you have children, is your relationship with them, Good Fair Poor

What other family do you have in the area? Mother Father Sister(s) Brother(s)
 Grandmother(s) Grandfather(s) In-Laws

Are there any ethnic or cultural considerations that we should be aware of? Yes No

If yes, what? _____

Do you: Own your own home Rent Other

How do you like your living arrangements? Good Fair Poor

Do you have enough money to pay your bills? Yes So-so No

Are you able to keep up with chores/responsibilities? Yes So-so No

Do you own /have use of a car? Yes No

Any current hobbies or interests? Yes No What? _____

Do you have any pets? Yes No

FAMILY/CHILDHOOD BACKGROUND

Any difficulties with your birth? Yes No Don't know

What was your father like? _____

How did you and your father get along? Good So-so Bad

What was your mother like? _____

How did you and your mother get along? Good So-so Bad

How did your parents get along? Good So-so Bad

Any brothers or sisters? Yes No

How did you and your siblings get along? Good So-so Bad

Was your childhood overall, Good So-so Bad Can't remember much

Were you abused as a child? Yes No

How was your health as a child? Good So-so Bad

Any Childhood habits? Sleepwalking Nail biting Temper Tantrums Thumb Sucking

Running away Nightmares Bedwetting Fears

Childhood social activity? Too Little About right Too much

Did you get into any trouble as a child? Yes No

EDUCATION

Highest grade completed? Less than 12th grade High School Grad College

Are you currently in school? No Yes (Where?) _____

Any awards or honors while in school? Yes No

What kind of grades did you get? Above average Average Below Average

Were you in sports, band, clubs, etc? No Yes _____

Any problems with learning? Yes No

How did you get along with classmates? Good So-so Poor

How did you get along with teachers? Good So-so Bad

MILITARY HISTORY

Ever in the Military? Yes No (skip this section)

Branch? _____ Mos/jobs? _____

Where stationed? _____ Dates of service? _____

WORK HISTORY (Complete all that apply)

Are you working? No Yes, as a _____

How long have you been at this job? _____

How do you feel about your job? Enjoy it Tolerate it Dislike/Hate it

Any special job skills? No Yes What? _____

How do you get along with your boss/supervisor? Good Fair Poor

How do you get along with your co-workers? Good Fair Poor

Accidents on the job? Yes No

Problems with being absent? Yes No

Ever fired from a job? Yes No

Previous jobs held: _____

SOCIAL HISTORY

Do you have anyone you can talk to about your concerns? Yes No

Is your current social activity, Too little About right Too much

Is there anyone you would like to see more often? Yes No

If yes, who? _____

Do you have any sexual concerns? Yes No

If yes, please describe. _____

LEGAL HISTORY

Are you currently involved with the legal system? Yes No

Have you ever been convicted of a felony? Yes No

Any past or current drug or alcohol related charges? Yes No

PERSONAL AND FAMILY HEALTH HISTORY

How is your health? Very Good Good Fair Poor Very Poor

Who is your family doctor? _____

When did you last see a doctor? _____ weeks/ months/ years ago (Circle one)

What medications are you currently taking? _____

Have you ever been hospitalized? Yes No

If yes, what for? _____

Have you ever taken tranquilizers or sedatives ("nerve pills")? Yes No

Are you allergic to any drug, medicine, or food? Yes No If yes, what? _____

Please Indicate Yes (Y) or No (N) if you or any blood relative has had an illness listed below.

Include who has had the illness.

___ Allergies (Medicines, food, environmental) _____

___ Alcoholism or drug addiction _____

___ Autoimmune disease (Lupus, MS) _____

___ Blood disease (Hemophilia, Anemia) _____

___ Bone or joint disorders (arthritis) _____

___ Cancer (please identify type) _____

___ Chronic lung disease (asthma, bronchitis) _____

___ Deafness or blindness _____

___ Glandular disease (diabetes, thyroid) _____

___ Heart defect or disease _____

___ Kidney or Urinary disease _____

___ Mental or Emotional Problems (Please describe) _____

___ Nerve Disease (Cerebral Palsy, Fibromyalgia) _____

___ Neurological Problems _____

___ Other (Please specify) : _____

SUBSTANCE USE HISTORY

Have you ever taken (Check all that apply)?

Amphetamines/Speed Cocaine/Crack Marijuana PCP, Angel Dust

Hallucinogens (LSD, THC, Magic Mushrooms, Peyote) Inhalants (gas, glue, paint thinners)

Heroin, Codeine, Morphine

Do you use Nicotine? Yes No Have you ever used Nicotine? Yes No

Do you Drink? Yes No How much and how often? _____

RELIGIOUS INVOLVEMENT

Has spirituality/faith ever been important to you? Yes No

How would you describe your current spirituality (check all that apply)?

- Exciting Growing Stagnant Boring Non-existent Discouraging Frustrating
 Oppressive Frightening Other (describe) _____

Is your faith/spirituality helpful to you? A lot A little Not at all

Ever participate in any unusual religious/ spiritual practices? No Yes (explain) _____

Do you currently attend a place of worship? Yes No

If yes, where _____

FUTURE PLANS

Do you have any plans for the future (e.g., school, job change)? Yes No

What? _____

What are your goals for counseling treatment?

Would you like us to contact anyone regarding your counseling treatment? (Doctor, Psychiatrist, spouse, etc.) Yes No Who? _____

CURRENT STATUS: PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MIGHT HAVE A BETTER IDEA OF HOW YOU ARE DOING (circle the correct number);

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7
Sub-total							
						Total	

IS THERE ANYTHING ELSE YOU WOULD LIKE YOUR THERAPIST TO KNOW?

Thank you for your assistance.

This form was developed by the faculty of the Midwest Counseling Program at Ashland Seminary, Ashland, Ohio and adjusted for use at The Gentle Shepherd Counseling Center.