The Gentle Shepherd Counseling Center

Adult Intake and History Form

NAME _____AGE_____ DOB_____ DATE _____

CURRENT PSYCHOLOGICAL STATUS

What are you seeking help with? _____

How would you describe your problem(s)? _____

When did your problem(s) begin? _____

When do you experience relief from your problem(s)? _____

When do your problem(s) get worse? _____

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

_____

Have you ever been hospitalized for mental health reasons? □ Yes □ No

If yes, when? _____

Any past or current suicidal thoughts or attempts? □ Yes □ No

Does anyone in your family have mental health concerns? □ Yes □ No | Who? _____

DEMOGRAPHIC INFORMATION

Are you: □ Single □ Married □ Divorced □ Widowed □ Re-married

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

How long have you been married? _____

Any previous marriages? □ Yes □ No | How Many? _____

If applicable, please list the names and ages of your children: _____

_____

If applicable, how many pregnancies have you had? _____

Has infertility or pregnancy loss been an area of concern? □ Yes □ No

What role does your culture/ethnicity/race play in your life? _____

_____

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 □ Somewhat □ No

Do you have adequate transportation to achieve your goals? □ Yes □ No

Do you have any pets? □ Yes □ No

FAMILY/CHILDHOOD BACKGROUND

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

How did your parents get along? □ Good □ So-so □ Poor

Would you describe your childhood as traumatic? □ Yes □ No

If yes, please describe: _____

_____

Directions: Please check each item that corresponds with a person/group that are most meaningful in your life and select the level of support that feels most accurate to you. Leave blank if the relationship is not applicable.

✓	PERSON/GROUP	LEVEL OF SUPPORT
	Mother	□ Good □ Fair □ Poor
	Father	□ Good □ Fair □ Poor
	Siblings How Many [ ]	□ Good □ Fair □ Poor
	Children	□ Good □ Fair □ Poor
	Current Partner	□ Good □ Fair □ Poor
	Past Partner (EX)	□ Good □ Fair □ Poor
	Friends	□ Good □ Fair □ Poor
	Co-Workers	□ Good □ Fair □ Poor
	Boss/Management	□ Good □ Fair □ Poor
	School or University	□ Good □ Fair □ Poor
	Classmates	□ Good □ Fair □ Poor
	Teacher(s)	□ Good □ Fair □ Poor
	Social Group(s)/Church	□ Good □ Fair □ Poor
	Self-Help Groups (e.g. AA, NA, Dual-Recovery)	□ Good □ Fair □ Poor

EDUCATION

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

Are you currently in school? □ Yes □ No 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 Accommodation services? _____

MILITARY HISTORY

Were you ever in the Military? □ Yes □ No (skip this section)

Branch: _____ Specific Jobs: _____

Where stationed: _____ Dates of service:_____

WORK HISTORY (Complete all that apply)

Are you working? □ No □ Yes, as a _____

Current Place of Employment; Title: _____

Years at current job? _____

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

Problems with being absent? □ Yes □ No

Ever fired from a job? □ Yes □ No

Previous jobs held: _____

Have substance related problems affected your work performance or employment? □ Yes □ No

LEGAL HISTORY

Are you currently involved with the legal system? □ Yes □ No

Have you ever been convicted of a crime? □ Yes □ No

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

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: _____

_____

PERSONAL AND FAMILY HEALTH HISTORY

How is your health? □ Good □ Fair □ Poor

Who is your family doctor? _____

What medications are you currently taking and for what reason? _____

_____

Directions: Please indicate with a checkmark if you or any blood relative has had an illness listed below. Include the specific illness and who has it in the description section.

✓	ILLNESS	SELF, FAMILY MEMBER(S) AND ILLNESS(ES)
	Allergies (Medicines, Food, Environment)	
	Alcoholism or Drug Addiction	
	Autoimmune Disease (Lupus, MS)	
	Cancer (Identify Type)	
	Chronic Lung Disease (Asthma, Bronchitis)	
	Glandular Disease (Diabetes, Thyroid)	
	Heart Disease or Cardiac Problems	
	Kidney or Urinary Disease	
	Mental or Emotional Problems (Schizophrenia, Bipolar, Anxiety, Depression)	
	Nerve Disease (Cerebral Palsy, Fibromyalgia)	
	Neurological Problems (Dementia, Alzheimers, Seizure Disorder)	
	Other (Please Specify)	

SUBSTANCE USE HISTORY

Have you ever felt you should cut down your use/behavior? □ Yes □ No

Have you ever been annoyed at someone's comments about your use/behavior? □ Yes □ No

Have you ever felt guilty about your use/behavior? □ Yes □ No

Have you ever had any substance related injuries or illnesses? □ Yes □ No

In the past year, have you used a prescription medication for nonmedical reasons? □ Yes □ No

SUBSTANCE USE GRID: PLEASE FILL OUT FOR ANY SUBSTANCE USED BELOW:

SUBSTANCE	AGE BEGAN	# OF YEARS	AMOUNT/ FREQUENCY	LAST USED
Alcohol				
Barbiturates (Amobarbital, Phenobarbital, Nembutal)				
Benzodiazepines (Ativan, Valium, Xanax)				
Cocaine/Crack				
Caffeine				
Ecstasy/MDMA				
Hallucinogens				
Inhalants				
Marijuana				
Methamphetamine				
Opiates (Heroin, Vicodin, Oxycotin)				
Stimulants (Ritalin, Adderall)				
Tobacco/Nicotine				

RELIGIOUS INVOLVEMENT

Is religion or spirituality an important part of your life? □ Yes □ No

Do religious or spiritual beliefs influence your life? (i.e. the way you look at your problems, the way you think about yourself and your life)? □ Yes □ No

Are there spiritual needs or concerns you would like to discuss? □ Yes □ No

How do you identify yourself spiritually (or denominationally)? _____

Do you currently attend church or religious services? If yes, where? _____

FUTURE PLANS

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

If yes, what? _____

What are your goals for counseling treatment? _____

_____

What do you hope will be different in your life one year from now? _____

_____

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

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

Thank you for your assistance.

This form was developed by the Leadership Team in coordination with the Clinical Treatment Team of

The Gentle Shepherd Counseling Center.