

The Gentle Shepherd Counseling Center 2022

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	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Father	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Siblings How Many []	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Children	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Current Partner	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Past Partner (EX)	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Friends	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Co-Workers	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Boss/Management	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	School or University	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Classmates	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Teacher(s)	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Social Group(s)/Church	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Self-Help Groups (e.g. AA, NA, Dual-Recovery)	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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.