Today's Date: _____

TrueHearted Counseling
Stephen Eller, LPC

Intake Form for Adults

Personal Information

Client

Name: _____ Birthdate: _____ Age: _____

Preferred Name / Nickname: _____ Gender is ☐ Male ☐ Female ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number (1): _____ ☐ Cell ☐ Work ☐ Home

Phone Number (2): _____ ☐ Cell ☐ Work ☐ Home

E-mail Address (1): _____

E-mail Address (2): _____

Preference(s) for Messages:
☐ Phone Number (1)
☐ Phone Number (2)
☐ E-mail Address (1)
☐ E-mail Address (2)

Background Information

Employment

Are you currently employed? ☐Yes ☐No (*If not, enter most recent employment below*)

Occupation: _____ Employer: _____

Education

How much of your education have you completed?

☐ Did not finish high school / Currently in high school ☐ Finished high school ☐ GED ☐ Some college completed
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree ☐ Post-Doctoral Work

Any current plans to further your education? ☐Yes ☐No

Who referred you to TrueHearted Counseling? _____

Have you been referred to counseling by the criminal justice system? ☐Yes ☐No

Are you currently on probation or parole? ☐Yes ☐No

Your Emergency Contact Information

Full Name: _____ Relationship: _____

Phone Number (1): _____ Phone Number (2): _____

Important Relationships

Your current relationship status: ☐ Single/Unmarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

If other, please describe: _____

Do you have a close, supportive relationship with any of the following people? Check *all* who apply.

☐Spouse or Partner ☐Parents or Step-Parents ☐Sibling(s) ☐Other relatives ☐Friends ☐Children

Have you had periods of significant problems with any of the above people? ☐Yes ☐No

If so, who? _____

Your usual living arrangements in the past *two* years (check *all* that apply):

☐Alone ☐With spouse or partner ☐With parent(s) ☐With other relatives ☐No stable arrangements

☐Other: _____

Please list your marriages or other important relationships with significant others:

Spouse / Partner	Year Begun	Year Ended	Children from this relationship (include ages)

Please list significant family members:

Relative	Name	Living?	Current Age (or age at death)	Occupation	Comments (Optional)
Father		☐Yes ☐No			
Mother		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			

Health Information

Do you take any medications? ☐Yes ☐No

List names and doses of all medications: _____

_____

Who prescribed these? _____

Recreational drugs you have used: _____ (In last 60 days? ☐Yes ☐No)

Childhood Experiences

Would you say that you experienced any of the following during your childhood? Check *all* that apply.

☐Physical violence (or fear that it might happen) ☐Emotional abuse (e.g., often being sworn at, insulted, or humiliated)

☐Physical neglect (i.e., not given food, shelter, medicine) ☐ Emotional neglect (i.e., constantly not feeling loved or supported)

☐Lived with someone who was depressed or mentally ill for long periods of time ☐Witnessed a parent treated violently

☐A household member went to prison ☐A household member was a problem drinker or used street drugs

☐Sexual molestation or abuse ☐Divorce or separation of parents

Comments: _____

_____

☐***Check here if you would prefer to discuss this section in person***

Please list any major or important **medical events** or recurring problems which have happened in your life (for example, illnesses or diseases, hospitalizations, significant accidents or injuries, surgeries, loss of consciousness, or seizures):

_____

_____

_____

_____

Counseling History

Is this your first time to see a counselor? ☐Yes ☐No

If not, list previous counselor(s) and reason(s) for treatment: _____

_____

Was this a positive experience? ☐Yes ☐No ☐Mixed

Have you ever been treated for any psychological or emotional problems? ☐Yes ☐No

If so, where? _____

Safety Information

Have you **ever** attempted suicide, talked about suicide, or harmed yourself in any way? ☐Yes ☐No

Is this **currently** happening? ☐Yes ☐No

Family History

Please check any major events (past or present) which have affected you **in the past few years**:

☐Physical disability ☐Frequent moving ☐Serious illness ☐Psychiatric disorder ☐Persistent money problems

☐Legal problems ☐Attempted or completed suicide in family ☐Death of a loved one ☐Physical or sexual abuse

☐Trauma (natural disaster, car accident, etc.) ☐Other: _____

Has anyone in your family **ever** struggled with the following (treated or not)? Check *all* that apply:

☐Depression ☐Bipolar Disorder ☐Learning problems ☐Drug abuse ☐Problem drinking

☐Schizophrenia ☐Physical or sexual abuse ☐Attempted or completed suicide

☐Other: _____

Current Concerns

Please check any categories that apply. Marking specifics is optional. Either way, we will discuss these in detail when we meet:

☐ **Anxiety**	☐ **Mood**	☐ **Anger**
Check this if you child: worry a lot, have inhibitions, struggle with perfectionism, have moments of panic, have obsessive thoughts, etc.	Check this if you: feel sad most of the time, fell stressed or tense, have unexpected or intense mood changes, lost interest in things you used to love, etc.	Check this if you: are easily frustrated, have a short fuse, notice anger affecting your relationships or work, feel like your anger is out of control, etc.

☐ **Concerning Habits**	☐ **The Future**	☐ **The Past**
Check this if you: have trouble with your sleep or eating, think you may have an addiction (drugs, alcohol, sex, gambling, eating, relationships, and so on), etc.	Check this if you: have trouble setting goals, can't stay motivated, have concerns related to your career or your education, have fear about the future, etc.	Check this if you: feel like events from the past are an obstacle to you, struggle with memory problems, can't seem to move forward with your life, etc.

☐ **Primary Relationship**	☐ **Family**	☐ **Difficult Experiences**
Check this if you: have struggles related to your spouse or partner (or lack thereof), including frequent arguments, distance, loneliness, sexual concerns, etc.	Check this if you: have concerns related to family members, including parenting concerns, setting boundaries, dealing with tension, etc.	Check this if you: have experienced something traumatic (e.g., a natural disaster, car accident), lost a loved one, have upsetting flashbacks, etc.

☐ **Health Concerns**	☐ **Legal Concerns**	☐ **Self-Worth or Identity**
Check this if you: have a medical or health-related concern that causes a lot of stress, fear that your habits may be causing such problems, etc.	Check this if you: are struggling with debt, were referred for counseling by the legal system, or have other concerns arising from contact with the justice system, etc.	Check this if you: have low self-esteem, have concerns related to sexual identity, have religious or spiritual struggles, lack purpose or personal meaning, etc.

☐ **Safety**	☐ **Specific Diagnosis or Other Concerns**
Check this if you: have suicidal thoughts, have **ever** tried to commit suicide, are being abused (physically, sexually, emotionally), are being stalked, etc.	Check this if your concerns are not covered here *or* ***if you have a specific diagnosis*** (such as ADHD, Autism, etc.). Comments: