

# COUNSELING STRATEGIES, LLC

## ADULT INTAKE FORM

CLIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE\* \_\_\_\_\_ E-MAIL\* \_\_\_\_\_  
OKAY TO LEAVE VOICEMAIL?  YES  NO TEXT?  YES  NO OKAY TO LEAVE MESSAGE?  YES  NO \*USED FOR SCHEDULING ONLY, NOT CONFIDENTIAL

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

### RELATIONSHIP STATUS

- SINGLE  CO-HABITATING  SEPARATED  RE-MARRIED  
 DATING  MARRIED  DIVORCED  WIDOWED

### OTHERS LIVING IN THE HOME

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ AGE \_\_\_\_\_

BRIEFLY DESCRIBE YOUR CHALLENGES \_\_\_\_\_

BRIEFLY DESCRIBE YOUR STRENGTHS \_\_\_\_\_

BRIEFLY DESCRIBE YOUR GOALS FOR THERAPY \_\_\_\_\_

HAVE YOU EVER BEEN SEEN BY ANOTHER COUNSELOR?  NO  YES PSYCHIATRIST?  NO  YES

WHOM? \_\_\_\_\_ DATES \_\_\_\_\_ OUTCOME \_\_\_\_\_

WHOM? \_\_\_\_\_ DATES \_\_\_\_\_ OUTCOME \_\_\_\_\_

WHOM? \_\_\_\_\_ DATES \_\_\_\_\_ OUTCOME \_\_\_\_\_

DO YOU HAVE A MENTAL HEALTH DIAGNOSIS?  NO  YES

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ PRESCRIBER \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ PRESCRIBER \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ PRESCRIBER \_\_\_\_\_

### CURRENT STRESSORS

- SEPARATION OR DIVORCE  CAREER CHANGE  
 SIGNIFICANT LOSS (FAMILY/FRIEND/PET)  LEGAL PROBLEMS  
 FINANCIAL PROBLEMS  ACCIDENT/ILLNESS  
 RELOCATION #TIMES \_\_\_\_\_  OTHER \_\_\_\_\_

### FAMILY HISTORY (PLEASE PROVIDE DETAILS WHEN APPROPRIATE)

SUBSTANCE USE \_\_\_\_\_

PHYSICAL ABUSE \_\_\_\_\_

SEXUAL ABUSE \_\_\_\_\_

FAMILY VIOLENCE \_\_\_\_\_

MENTAL ILLNESS \_\_\_\_\_

OTHER \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_