Healing Hearts
Family Counseling Inc.
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CLIENT INFORMATION / INTAKE FORM – ADULT

Name: _____ Date: _____
First Middle Last

Address: _____

City / State: _____ Zip Code: _____

Home Phone: ( ) _____ E-mail: _____

Work #: ( ) _____ Cell #: ( ) _____

What is the best number to reach you? ☐Home ☐Cell ☐Work ☐Other: _____

May we leave a message? ☐Yes / ☐No May we leave a text message? ☐Yes / ☐No Other: _____

*Of all of the methods given above, is there a method you **DO NOT** wish to be used?* _____

I am child # _____ in a family of _____ children. I was adopted: ☐Yes / ☐No

Age: _____ Date of Birth: _____/_____/_____ Ethnicity: _____

Gender: ____ Female ____ Male Social Security No.: _____ Employed? ☐Yes / ☐No

Occupation: _____ How long? _____

Employer: _____

Employer Address: _____

Currently in School? ☐Yes / ☐No If so, ☐Full-Time / ☐Part-Time Highest Grade Level Completed _____

MARITAL & FAMILY INFORMATION

Relationship Status: ☐ Single ☐ In Relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

# of Previous Marriages: _____ # of Previous Marriages for Spouse/Significant Other: _____

# of Years Married: _____ # of Years in Current Relationship: _____

# of Years Divorced: _____ Length of Separation: _____ # of Pregnancies: _____ # of Children: _____

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Please list children by age (include step, adopted, and foster children):

Name	Age	Sex	Education/Grade	Lives With?	Relationship to You	Concerns?

Please list any other person(s) living in your home:

Name	Age	Sex	Relationship	Concerns?

Family History - Indicate if any of the following is true for any family members:

	Self	Mother	Father	Sibling	Grandparent	Other – Please specify
Anxiety						
Depression						
Suicide						
Suicide Attempt						
Alcohol Problem						
Drug Problem						
Mental / Emotional Problem						
Abuse						
Other Major Trauma (accident, rape, combat, etc.)						

MEDICAL HISTORY

Physician:_____ Phone #: ( ) _____

Address:_____
Street City State Zip

Date of Last Exam: _____ General Health Assessment: _____

Current illness(es) being treated? ☐ Yes ☐ No Specify:_____

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Mark any of the following medical conditions you have or have had in the past:

Heart trouble ____	High Blood Pressure ____	Fainting/dizziness ____
Diabetes ____	Shortness of Breath ____	Stomach problems ____
Stroke ____	Bedwetting/Soiling ____	Neurological disease ____
Back problems ____	Sleep difficulty ____	Epilepsy ____
Arthritis ____	Unusual bleeding ____	Meningitis/Encephalitis ____
Kidney trouble ____	Seizures/Convulsions ____	Asthma/Hay Fever ____
Head injury/knocked unconscious ____	Frequent/Severe Headaches ____	

Please list all medications you are currently taking (including non-prescriptions such as vitamins, etc.):

Name of Medication	Dosage & How Many Times per Day	Prescribing Physician

Please list any other serious illness, injury, or surgery:

Type of Illness/Injury/Surgery	Name, Address & Phone # of Treating Physician	Date of Illness/Injury/Surgery

Prior Psychotherapy -> Have you consulted with a therapist in the past? □Yes / □No Please specify:

Name of Psychotherapist	Address & Phone #	Date(s) of Service

Have you been hospitalized for any psychiatric reasons in the past? □Yes / □No Please specify:

Name of Hospital	Address & Phone #	Date(s) of Hospitalization

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EMERGENCY CONTACT INFORMATION

Please provide the names of people we can contact in case of an emergency:

Name	Phone #	Relationship to You

<u>Appointment Cancellation Policy</u>:

If an appointment is cancelled or missed without 24 hours prior notice, a regular charge will be made and carried as a balance with payment due at the next appointment. Please note that Monday appointments must be cancelled by noon on Friday.

_____ Initials

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Problem Areas/Areas of Concern

		During the past **TWO (2)WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Clinician Use Only** (Highest Domain Score)
I.	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feel down, depressed, or hopeless?	0	1	2	3	4	
II.	3.	Feeling more irritated, grouchy, angry than usual?	0	1	2	3	4	
III.	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6.	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you nervous?	0	1	2	3	4	
V.	9.	Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12.	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15.	Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks of any kind of alcohol in the same day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g. painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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Please briefly write about the problem(s) or areas of concern that brought you to counseling:

_____

_____

_____

_____

_____

_____

_____

_____

Please describe the goals you hope to gain from counseling:

1. _____
2. _____
3. _____
4. _____

Have things improved since you made the initial appointment? ____ YES / ____ NO

If so, how have things improved? _____

_____

_____

Who referred you to our office? _____

This form was completed by: _____ Date: _____
Name