LIFE ON THE GROW
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ADULT CLIENT INTAKE FORM

Date: _____

Basic Information:

Name: _____ DOB: _____ / _____ / _____ Age: _____

Home Address: _____ City: _____ Zip: _____

Cell Phone: _____ E-mail: _____

Referred or found me by: _____

Relationship Status: _____

Occupation: _____ Employment Status: _____

How do you like your work? _____

Emergency Contact: Name_____ Relationship to you: _____

Main phone: _____

Primary Care Physician: _____ Phone:_____

Names and Ages of any Children: _____

_____

Anyone else living in the home?: _____

INTAKE QUESTIONS:

What motivated you to look for a counselor/coach at this time? _____

_____

_____

What do you wish to change or accomplish as a result of therapy? _____

_____

_____

What have you already tried to solve this problem? _____

_____

Have you been in therapy before? If yes, how was your experience?: _____

_____

What are your strengths? _____

_____

Please circle any of the following areas that you would like to address in counseling/coaching:

Feelings/Mood	Career/education
Family	Phase of life
Children/Parenting	Stress
Relationships	Assertiveness
Alcohol or Drug use	Health Problems
Abuse Issues	Childhood experiences
Spirituality	Loss or death
Self-esteem	Legal Issues

Please CIRCLE all that apply and indicate for HOW LONG:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Panic Attacks
Irritable and/or short temper	Mood Swings
Significant change in weight	Decreased need for sleep
Low energy level/fatigue	Feel more talkative than usual
Feeling excessive guilt or shame	Excessive spending/shopping
Unable to relax	Excessive gambling
Lack of appetite/increased appetite	Relationship Problems
Loss of interest in activities/hobbies	Intimacy Issues
Feeling hopeless	Substance Abuse
Feeling worthless	Risky behaviors
Difficulty motivating	Troubling thoughts about the past
Withdrawn/isolating self	Nightmares
Cry easily/often	Startle easily
Difficulty making a decision	Too neat and orderly
Difficulty finishing tasks	Repeating certain behaviors over and over
Difficulty with Friends/Family	Painful Memories
Thoughts to hurt self or others	Easily upset or angered
Physical Pain	Feeling different from most people
	Shy around others
	Increasingly forgetful
	Strong fears
	Difficulty with work or school

MEDICAL HISTORY : (If yes, please elaborate on what and how much?)

Have you consulted a physician or psychiatrist regarding the problem that brings you here?

_____

Are you currently being treated for any medical problems? _____

Are you currently taking any medications? _____

If Yes, Please indicate what medications: _____

Are you presently in good health? _____

Do you engage in physical activity?_____

Do you smoke cigarettes? _____

How much alcohol do you drink? _____

Do you drink caffeinated beverages? _____

Do you use any other types of drugs? _____

Have you ever tried to cut down or stop using alcohol or drugs? _____

Have you ever been hospitalized for any emotional / mental health condition? _____

If Yes, Please indicate for what and how long? _____

PERSONAL HISTORY

Have you experienced or witnessed a traumatic event? *Yes or No*

Do you have a history of domestic violence? *Yes or No*

Do you have a history of verbal, emotional or physical abuse? *Yes or No*

Do you have a history of sexual abuse or sexual assault? *Yes or No*

Are you or have you experienced legal problems? *Yes or No*

If Yes on any of the above, please elaborate: _____

_____

FAMILY HISTORY:

Have you or anyone in your family experienced any of the following?
If yes, please note their relationship to you, and include details if possible.

Have you or a family member experienced:	***Indicate Self or which Family Member (s):***
Anxiety	
Depression	
Bipolar Disorder	
Attention Issues or Hyperactivity	
Illicit Drug Use	
Alcohol Abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or Completed Suicide	

SUPPORT SYSTEMS	**Please elaborate a little.**
Do you have a friends or family member that you consider close and feel you can depend on?	
Do have a religion or spiritual practice that you experience as supportive?	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	

Is there anything else that you would like to add?