Collaborative Counseling

Adult Intake Form

Client's name: _____ Date of birth: _____

Form completed by (if someone other than the client): _____

Best number to reach you at: _____ Circle: Home Cell Work

Emergency contact: _____ Phone: _____

Please state briefly why you are seeking treatment at this time: _____

_____

Do you have a Primary Care Physician and/or Psychiatrist? Circle: YES NO

Name of Doctor(s): _____

Would you like your therapist to coordinate care with your physician? Circle: YES NO

Please check any of the following behaviors and characteristics you would like to occur less in your life:

	Physical Aggression		Blames Others
	Verbal Anger		Careless/Reckless
	Anxious		Impulsive
	Mind racing		Impatience
	Avoidance		Uncooperative
	Day dreaming		Defiant/Oppositional
	Fear/Panic		Legal problems
	Irritability		Lying
	Crying Spells		Obsessions/Rituals
	Depressed mood		Inattention
	Difficulty with change		Rigid Thinking
	Lack of motivation		Nightmares
	Withdrawn		Sleep problems (wakeful/falling)
	Worthlessness/Guilt		Appetite Disturbance
	Physical complaints		Weight loss/Weight gain
	Helpless Feelings		Hallucinations
	Moody/Mood swings		Substance Use Problems
	Distrusts Others		Cutting/Self Injury
	Relational Problems		Homicidal Thoughts/Plans
	Social Deficits		Suicidal Thoughts/Plans
	Destroys Property		Other:
	Temper Tantrums		Other:

How long have symptoms been present for? _____

Developmental/Childhood History

Were there any circumstances that affected your development while growing up? _____ Yes _____No

If yes, please describe:_____

_____

Any history of abuse (e.g. physical, emotional or sexual) or neglect? _____ Yes _____No If yes, please describe: _____

_____

Anything else you would like to disclose that might be relevant to therapy? _____

_____

Client Mental Health and/or Chemical Dependency Treatment History (Both Current and Past)

Prior Outpatient Treatment

Dates	Clinic	Therapist	Diagnosis/Reason for Treatment
_____	_____	_____	_____
_____	_____	_____	_____

Inpatient Hospitalization for Mental Health Issues

Dates	Clinic	Therapist	Diagnosis/Reason for Hospitalization
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any history of suicidal ideation or suicide attempt(s)? ____ Yes ____No If yes, please describe:

_____

Do you have any current suicidal ideation? _____ Yes _____No If yes, please describe: _____

_____

Chemical Dependency Assessment/Treatment

Dates	Clinic	Therapist	Diagnosis/Reason for Treatment
_____	_____	_____	_____
_____	_____	_____	_____

Number of times in Treatment for CD Issues: _____

Medical History and Physical Health

List any past health concerns, conditions or procedures: _____

_____

_____

List any current health concerns or conditions: _____

_____

_____

Please list any allergies: _____

List any current medications (both prescribed and over-the-counter):

Medication name	Dosage	Dates taken	Purpose	Side effects	Benefits (e.g. Is it working?)

Please list your most recent examinations:

	Date	Reason	Results
Physical exam			
Doctor's visit			
Vision exam			
Hearing exam			
Dentist visit			
Surgery			
Other:			

Have there been any recent changes in the following? (Check all that apply)

	Sleep		Mood/Disposition		Behavior
	Appetite		Weight gain or loss		Other:

Describe any changes you have noticed recently: _____

_____

Chemical Use History

Do you use or have any problems with drugs, nicotine and/or alcohol? _____Yes _____No If yes, complete:

Please list any substance use (including alcohol, nicotine, unprescribed medications or other illegal drugs:

Substance	Method and amount used	Frequency of use	Age of first use	Last use/most recent date of use

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)	YES	NO
1. Have you felt you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		
Yes = 1. No = 0. 2/4 or greater = positive CAGE, further evaluation is indicated.	Score: ___/4	

What is/are your substance(s) of preference: _____

What are your reasons for using? (e.g. addicted, build confidence, escape, social, medicate, etc…) _____

_____

Describe when and where you typically use substances: _____

_____

How has your substance use affected your life? _____

_____

Describe any changes in your substance use: _____

_____

Do you believe your substance use is a problem? _____ Yes _____No Please describe:_____

_____

Does anyone support your in stopping or limiting your substance use? _____ Yes _____ No

If yes, describe: _____

Anything else you want to report? _____

Educational History

Highest Education Received _____

Are you currently in school? _____Yes _____No If yes: _____

Are there any academic concerns? _____Yes _____No If yes: _____

Do/Did you have any specialized learning needs? ___Yes ___No If yes: _____

Career/Work History

Currently employed? _____Yes _____No If yes, what is your position?_____

Are you satisfied in your current job or career? Describe. _____

_____

Are there any goals you have related to your career or work? ___Yes ___No Describe:_____

_____

Have you ever served in the military/marines/coast guard/other related agency? __Yes ___No

If yes, please describe:_____

_____

Legal History

Do you have any history of legal issues? ____Yes _____No If yes, please describe: _____

_____

Do you have any current or pending legal issues? ____Yes _____No If yes, please describe: _____

_____

Cultural/Ethnic

Do you or your family belong to any cultural or ethnic group? _____Yes _____No If yes, please describe:

_____

Are you experiencing any cultural or ethnicity-related problems? ___Yes ___No If yes, please describe:

_____

_____

Anything else you would like to note regarding culture and ethnicity? _____

Religion/Spirituality

Do you or your family belong to any religious and/or spiritual group? ____Yes _____No If yes, please

describe: _____

Are you experiencing any religion/spirituality-related problems? ___Yes ___No If yes, please describe:

_____

How important is religion/spirituality to you? _____

Anything else you would like to note regarding religion/spirituality? _____

_____

Social/Peer Relationships

Are you satisfied with your current social life? ___Yes _____No Please describe: _____

_____

How would you describe your social tendencies? (Check all that apply)

	Leader		Difficulty making friends		Gets bullied
	Follower		Bossy		Loner
	Outgoing		Well liked by peers		Other:
	Shy/Reserved		Bullies others		Other:

Abuse/ Trauma History

Has the client been a victim or at risk for emotional, physical or sexual abuse? ___Yes ___No

Describe: _____

_____

Other trauma/losses: _____

Leisure/Recreational Activities

Describe your special areas of interest, hobbies and activities: _____

_____

_____

Family History

Is there any family history of mental health concerns and/or substance use concerns? _____Yes _____No

If yes, please complete the following:

Family member	Diagnosis/Issue(s)	Treatment received	Other information

What is your current family situation*?* Married: _____ Separated/Divorced: _____ Single: _____ Other: _____

People living in household with client

Name	Relationship (e.g. sibling, parent, cousin)	Age	List any mental health or substance use concerns they have and anything notable about your relationship with them

Have you had any divorce(s), major breakups with a significant other, etc…? ___Yes ___No

If yes, please describe: _____

Is there any information about your current living situation that may be beneficial to therapy? __Yes __No

If yes, please describe: _____

Family of Origin

Client's Family History

Parents	Age	Relationship History

Siblings	Age	Relationship History

Please list any mental health or substance use concerns within you family of origin: _____

_____

Have you had any divorce (s), major break ups with a significant other: ___Yes___No

If yes please describe:_____

Have you moved multiple times: ___Yes ___No If yes please describe: _____

_____

Other Significant Relationships

Name	Relationship (i.e. significant other, friend, cousin, etc…)	Age	List any mental health or substance use concerns and anything notable about your relationship with them

Other Questions for Therapy

Any additional information you think would assist in our understanding of you or your current situation?

_____

_____

What are your goals for therapy? _____

_____

_____

Would you like to see any family (or others in your life) involved in your therapy? _____Yes _____ No

If yes, describe: _____

_____

What do you consider to be your strengths? _____

_____

What do you consider to be your weaknesses? _____

_____

For Staff Use Only

Therapist's comments: _____

_____

_____

_____

_____

_____

Therapist's signature: _____ Date: _____

Physical exam: _____ Required _____ Not Required