ADULT INTAKE FORM

A New Perspective Counseling

Name:_____ Age:_____ Sex: _____ Date of Birth: ____/____/_____

Street Address:_____ Phone (h): _____

City, State, Zip:_____ Phone (w): _____

Email Address:_____ Phone (c): _____

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Current Marriage/Separation:_____ Number of Marriages: _____

Street Address:_____ Phone (h): _____

Spouse's Name:_____ Date of Birth: _____

Number of Children and Ages:_____

Presently living with: ☐ Parents ☐ Spouse ☐ Roommate ☐ Alone ☐ Other _____

Emergency Contact:
Name:_____ Phone:_____ Relationship to you: _____

Who referred you or how did you hear about ANP?_____

Please list specific days/times for your appointment availability (check all that apply):

Monday	☐ morning ☐ afternoon ☐ evening	*Tuesday*	☐ morning ☐ afternoon ☐ evening	*Wednesday*	☐ morning ☐ afternoon ☐ evening	*Thursday*	☐ morning ☐ afternoon ☐ evening	*Friday*	☐ morning ☐ afternoon ☐ evening	*Saturday*	☐ morning ☐ afternoon

What type of counseling are you seeking? *Please select one:*

Type	Description	Forms Required
☐ INDIVIDUAL	1-on-1 counseling	1 intake form
☐ FAMILY	2 or more family members	1 intake form per person over 18 yrs. old
☐ RELATIONSHIP	Couples who are dating	1 intake form per person (total of 2 forms)
☐ PRE-MARITAL	Couples engaged or considering it	1 intake form per person (total of 2 forms)
☐ MARITAL	Couples needing marital guidance	1 intake form per person (total of 2 forms)

REASONS FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

Where are your concerns causing the most problems for you? (Check all that apply): ☐ Home ☐ Work ☐ Marriage ☐ Other Relationships ☐ God

When did your present concerns begin to be a problem for you? _____

Have any concerns about you been identified by others? _____

Please rate the severity of your present concerns on the following scale (Check one): ☐ Mild ☐ Moderate ☐ Severe ☐ Totally Incapacitating

Please indicate which of the following areas are currently problems for you (Check all that apply):

☐ Under too much pressure / feeling stressed
☐ Excessive anxiety or worry
☐ Feeling Lonely
☐ Angry Feelings
☐ Feeling "numb" or cut off from emotions
☐ Angry outbursts
☐ Excessive fear of specific places / objects
☐ Difficulty making friends
☐ Feeling as if you'd be better off dead
☐ Feeling manipulated or controlled by others
☐ Difficulty making decisions
☐ Loss of interest in sexual relationships
☐ Feeling sexually attracted to members of your own sex
☐ Concerns about physical health
☐ Blackouts or temporary loss of memory
☐ Insomnia (no sleep) or Hypersomnia (sleep all the time)
☐ Loss of appetite / increased appetite
☐ Issues with food and / or weight
☐ Abuse of alcohol and / or non-prescription drugs
☐ Delusions
☐ Feeling distant from God
☐ Hallucinations
☐ Inability to concentrate while at school / work
☐ Crying Spells
☐ Nightmares
☐ Loss of interest in usual activities / lack of motivation
☐ Obsessions or compulsions with specific activities
☐ Inability to control thoughts
☐ Feeling trapped in rooms / buildings
☐ Hearing Voices
☐ Feeling that people are "out to get you" or you're being watched

MEDICAL/HEALTH INFORMATION

How would you rate your current physical health? ☐Excellent ☐Good ☐Fair ☐Poor Date of last physical examination: / /

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) ☐ Yes ☐ No

If yes, please explain: _____

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Previous hospitalizations for medical reasons: Date_____ Reason _____

Date_____ Reason _____

Have you ever been hospitalized for psychiatric purposes? ☐ Yes ☐ No

If yes, please explain including name of hospital, location and dates:

Permission to contact previous counselor: ☐Yes ☐No Please list names of any previous therapists, including dates and contact number:

How do you feel about the results of your previous counseling?

What do you hope to gain from counseling? _____

OCCUPATIONAL / EDUCATIONAL INFORMATION

Occupation:_____ Status: _____

Employer:_____ Present annual income: $ _____

If Currently a Student – Field of Study: _____ Degree: _____

Institution, University or College: _____ Status: _____

How long have you been with your current employer, and are you satisfied with your job? _____

RELIGIOUS BACKGROUND

Do you believe in God? ☐Yes ☐No Religious Preference: _____

How much influence does your religion have on your day-to-day activities? _____