HOPE Counseling Center
Healthy **O**utcomes for **P**ersonal **E**nrichment
All Counselors are supervised by a licensed Marriage and Family Therapist

Adult Intake Form

Date:_____ Client Name:_____

Therapist Name:_____

What are the issues that led you to decide to come to therapy?

What are your goals for therapy?

What are your strengths and limitations?

What do you enjoy doing in your free time?

Who is a source of support for you? Any family, friends, or groups you enjoy?

What is your current level of stress (overall)?

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Rank in order the top three concerns that you have in your life (1 being the most problematic)

1. _____

2. _____

3. _____

Have you received prior counseling related to any of the above concerns? ◯Yes ◯No

If yes, when: Length of treatment:

What was the outcome (check one)?

___Very successful __Somewhat successful ___Stayed the same ___Somewhat worse ___Much worse

What is your occupation?_____

Do you enjoy your job? ____Yes ____No

What was your relationship like with your family growing up?

Do you have children? ____Yes ____No Do they presently live with you? ____Yes ___No

Ages? _____ _____ _____ _____

Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? ____Yes ____No
If yes, please describe:

Has there been any ___ verbal, ___ emotional, ___ physical, or ___ sexual abuse that has happened to you? ____Yes ____No
If yes, was the assailant someone you knew? ____Yes ____No
When did this happen?

Where is this person now?

Have you ever had any legal issues? ◯ Yes ◯ No
If yes, please describe:

Are you currently experiencing any suicidal thoughts? ◯ Yes ◯ No

Have you had a suicidal attempt? ◯ Yes ◯ No
If yes, date of last attempt and treatment:

Has anyone in your family ever been treated for psychiatric reasons? ◯ Yes ◯ No
If yes, please describe:

Does anyone in your family have mental health diagnosis? ◯ Yes ◯ No

If yes, please describe who and their diagnosis:

Do you have any mental health diagnoses? ◯ Yes ◯ No
If yes, please describe:

Do you have a medical provider? ◯ Yes ◯ No
If yes, what is the name?

Do you have any medical issues? ◯ Yes ◯ No
If yes, please describe:

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Please list any medications you are currently taking, or have taken during the past 6 months. (Include prescribed and over the counter medications)

Medication	Dosage	Used for	Prescribing Doctor

Check any of the following symptoms or concerns that you are currently or have recently experienced:

- ☐ Stress
- ☐ Chronic Pain
- ☐ Loneliness
- ☐ Fatigue
- ☐ Relational issues
- ☐ Low self-esteem
- ☐ Compulsive behavior
- ☐ Grief
- ☐ Sexual addiction
- ☐ Poor Concentration
- ☐ Aggression
- ☐ Eating problems
- ☐ Controlling
- ☐ Obsessive thoughts
- ☐ Hearing voices
- ☐ Racing thoughts
- ☐ Loss of control
- ☐ Drug/Alcohol use
- ☐ Impulsive behaviors
- ☐ Sexual concerns
- ☐ Depression
- ☐ Gender identity
- ☐ Trouble sleeping
- ☐ Unwanted memories
- ☐ Pregnancy/Abortion
- ☐ Anxiety
- ☐ Fears
- ☐ Panic
- ☐ Anger
- ☐ Bad dreams

Please share information about substance use by **you or other people** who are significant in your life.

Substance	Who? Self or Other (identify relationship)	How much and how often	When last used?	Age started using
Caffeine				
Tobacco				
Alcohol				
Marijuana/Pot				
Cocaine/Crack				
Opiates/Narcotics (i.e. pain killers)				
Barbiturates/Sedatives/Tranquilizers				
Amphetamines/Stimulants				
Hallucinogens/LSD/Psychedelics				
Other:				

Any other information you think is important for me toknow?