Capital Valley Counseling Associates, Inc.
Adult Intake Forms

Contact & General Information

Client Name _____ DOB: _____ Marital Status_____

Spouse's Name: _____

Address _____ City/Town _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

May we leave a message at the Home phone? _____ Work phone?_____ Cell phone? _____

Email address: _____May we contact you by Email?_____

Emergency Contact:_____Phone_____

How did you find out about us and our services? _____

_____

Client Questionnaire

Please list date(s) and provider(s) of any prior counseling or other treatment: _____

_____

_____

_____

A. Why are you seeking counseling at this time? _____

_____

_____

_____

B. What do you hope to achieve through counseling? _____

_____

_____

C. Please rate how upsetting the above concern(s) is/are right now:
____ Mildly Upsetting ____ Moderately Upsetting ____ Very Upsetting ____ Extremely Upsetting

D. When did the problem(s) begin (give dates if possible)? _____

_____

E. In what ways have you tried to solve the problem(s), and who or what has been helpful?

_____

_____

F. Please list the members of your (or your child's) family by giving their first names and ages. Place a X by those with whom you live.

	Name	Age	If deceased, age at death/cause
Mother			
Father			
Siblings			
Spouse/partner			
Children			

G. If you have children under 18 who live outside of your home:
Who has legal custody? _____ Physical custody? _____
What are visitation agreements? _____

H. Is your family currently involved with any social service or legal or other agency? ____ No ____ Yes
If Yes, please explain:

_____
_____
_____

I. Check any of the following that apply to you (or your child) and indicate the person involved:

EVENT	SELF	CHILD	FAMILY MEMBERS	DATE
Divorce				
Financial Trouble				
Job/School Problems				
Abuse: emotional				
Abuse: physical				
Abuse: sexual				
Domestic Violence				
Suicide thoughts/ attempts				
Depression				

Anxiety				
Death of loved one (who?)				
Alcoholism				
Addictions (Describe)				
Physical/medical conditions				
Physical/medical conditions				
Physical handicap				
Other				

J. Please indicate the highest grade in school that you have completed and note any additional training.
_____

K. What is your current employment? _____
Position? _____ Number of years? _____
L. What are your hobbies/ leisure activities_____
_____
M. Do you have any religious or spiritual practices?_____
N. Do you have weapons in your home?_____ If so, where are they kept?_____
_____
_____

O. Is there anything else you want us to know about yourself?
_____
_____
_____

Medical Information

Name _____ Sex _____ Age ____
Height _____ Weight now _____ One year ago _____
Maximum weight (when?) _____ Weight you consider ideal _____

Current Prescribed Medications	Dosage	Prescriber's name

Substance Use	Current Amount	Past Amount
Cigarettes		
Caffiene		
Alcohol		
Street Drugs		
Pain Relief Meds		
Other Meds		

Surgeries / Hospitalizations _____

_____

_____

Other Medical Concerns/Conditions:_____

_____

_____

_____

Primary Care Provider _____ Date of last visit _____

Psychiatrist or Psychiatric Nurse Practioner_____

Adult Checklist of Concerns

Please check each line that applies and underline the specific items on the line that concern you. Feel free to add any others at the bottom of page 6 under "Any other concerns or issues." You may add a note or details in the space next to the checked concerns.

☐ Abuse – perpetrator of abuse.

☐ Abuse – victim of abuse.
☐ Addictions – gambling, screens/Internet/video games, pornography, substances.
☐ Aggression – physical toward people.
☐ Aggression – physical toward property.
☐ Anger, hostility, arguing, irritability.

- ☐ Anxiety, nervousness.
- ☐ Bizarre thoughts.
- ☐ Bullies/intimidates, teases, is bossy to others, instigates conflict, provokes others.
- ☐ Career issues/concerns.
- ☐ Cheating, lying, deceitfulness, dishonest.
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting, custody issues.
- ☐ Codependence, dependent on others.
- ☐ Compulsions
- ☐ Concern for others, empathy.
- ☐ Concerns regarding drug or alcohol use/abuse.
- ☐ Confusion
- ☐ Cruel to animals.
- ☐ Cries easily, feelings are easily hurt.
- ☐ Decision-making, indecision, putting off decisions.
- ☐ Delusions (false ideas)
- ☐ Depression, low mood, sadness, feelings of emptiness or hopelessness, feelings of failure.
- ☐ Divorce, separation.
- ☐ Dropping out of school.
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money problems, debt, impulsive spending, low income.
- ☐ Friendships / social issues.
- ☐ Gender identity issues.
- ☐ Grieving, mourning, deaths, losses, divorce.
- ☐ Guilt.
- ☐ Headaches, stomach aches, other kinds of pains.
- ☐ Health, illness, medical concerns, physical problems.
- ☐ Impulsiveness, loss of control, outbursts, interrupts, talks out.
- ☐ Inattention, poor concentration, distractibility.
- ☐ Interpersonal conflicts.
- ☐ Intolerant of ethnic/religious/gender/sexual orientation or cultural differences.
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Lacks respect for/conflict with authority.
- ☐ Learning disability.
- ☐ Legal difficulties – please specify_____
- ☐ Loneliness.
- ☐ Marital/partner conflict, distance/coldness, infidelity/affairs, remarriage.
- ☐ Memory problems.
- ☐ Menstrual problems, PMS, menopause.
- ☐ Mood swings.
- ☐ Nightmares
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection.

- ☐ Panic or anxiety attacks.
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Poor motivation, laziness.
- ☐ Procrastinate, waste time.
- ☐ Relationship problems.
- ☐ Rocking or other repetitive movements
- ☐ School problems (see also "Career concerns")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-harming behaviors – cutting, biting or hitting self, head banging, hair pulling, scratching self.
- ☐ Self-neglect, poor self-care – grooming, hygiene.
- ☐ Sexual – sexual preoccupation, inappropriate sexual behaviors.
- ☐ Sexual issues, dysfunctions, conflicts, desire differences.
- ☐ Shyness, oversensitivity to criticism, timid.
- ☐ Sleep problems – too much, too little, insomnia, nightmares.
- ☐ Somatic/illness/pain complaints, feeling sick frequently/always.
- ☐ Speech difficulties
- ☐ Stubborn, difficulty compromising.
- ☐ Suicidal talk, gestures, attempts.
- ☐ Suspiciousness
- ☐ Swearing, profanity.
- ☐ Temper problems, self-control, low frustration tolerance.
- ☐ Threatening to others verbally.
- ☐ Tics – involuntary rapid movements, noises, or word productions
- ☐ Under-active, slow-moving or slow-responding, lethargic
- ☐ Weight and diet issues
- ☐ Withdrawn, isolate from others.
- ☐ Work problems, employment, workaholism/overworking, can't keep a job.

Any other concerns or comments?_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____