Dialectical Counseling & Consulting Group, PLLC

Adult Intake Form

Personal Information Today's Date: _____

Last Name: _____First Name: _____M.I.:_____

Age: _____ Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Ok to send mail? _____ If no, please provide alternate address:

_____

EMAIL: _____

Home phone: _____ Ok to leave a message? _____

Cell phone: _____ Ok to leave a message? _____

Work phone: _____ Ok to leave a message? _____

Name of emergency contact: _____Relationship to you: _____

Address:_____

Home Phone: _____Cell/Work Phone: _____

Referral Source (how you heard about Shandra Ross or Dialectical Counseling & Consulting Group):

_____

_____

Health Information

Please answer the following questions using: **5 -Excellent, 4 -Good, 3 - Average, 2 - Poor, 1 - Failing**

How would you currently rate your physical health? _____

How would you currently rate your mental health? _____

How would you currently rate your spiritual health? _____ (if does not apply to you, please use N/A)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

_____

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_____

Medical Information

Do you now have, or have you had in the past, any of the following? *Circle all that apply:*

Asthma	Allergies	Headaches	Brain Injury
Epilepsy /Seizures	Digestive Disorders	Cancer	Diabetes
Breathing Problems	Immune System Problems	Heart Disease	High Blood Pressure
Vision Problems	Hearing Problems	Arthritis	Urinary Disorders
Tuberculosis	Thyroid Disorder	Multiple Sclerosis	Fibromyalgia
Chronic Fatigue Syndrome	Sleep Disorder	Serious Accident	Surgery

Sexually Transmitted Disease

Pregnancy (how many)_____ Miscarriage (how many)_____ Abortion (how many)_____

Are you currently under the care of a Doctor or other medical health professional? _____

Name of Primary Care Physician: _____ Physician Phone #: _____

Address:_____

Name of Specialist Physician: _____Physician Phone#: _____

Address: _____

Please list any prescription medications you are currently taking:

_____

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_____

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_____

_

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____

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_____

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_____

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Do you currently exercise? _____ If yes, please indicate how many times per week: _____

Substance Use

Substance	Age first use	Past use (amount/frequency)	Current use (amount/frequency)	Last used?	Additional info?
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Ecstasy					
Cocaine/Crack					
Heroin					

Methamphetamines					
PCP/LSD/Mushrooms					
Pain Killers					
Steroids					
Diet Pills					
Sleeping Pills					

Have you ever believed your substance use was a problem for you?_____
Has anyone ever told you they believed your substance use was a problem?_____
Have you ever had withdrawal symptoms when trying to stop using any substances?_____
If yes, please describe: _____

_____

_Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?_____
If yes, please describe: _____

_____

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_____

_Have you ever participated in drug and alcohol treatment? _____ If yes, please list type, length, dates, and age at time you received these services: _____

_____

_ Do you currently or have you ever attended Alcoholics or Narcotics Anonymous? _____ If yes, please list length of time sober and number of meetings you attend per week: _____

Mental Health Information

Have you ever been in counseling/therapy before? _____ If yes, did you find it helpful or effective? _____
Are you currently receiving mental health services? _____ If yes, please list name of practitioner and type of services you are receiving:

_____

_____

_Have you ever been hospitalized for mental health concerns? _____ If yes, list date(s) and length of stay:

_____

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_____

_ Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:

_____

_____

__ Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) & illness(es):_____

_____

__

Have you ever or are you currently engaging in self harm? Currently: _____ Past: _____
Have you ever or are you currently contemplating suicide? Currently: _____ Past: _____
Have you ever or are you currently contemplating harming another person? Currently: _____ Past:_____
Have you ever attempted suicide? _____ If yes please list date(s), method(s), and your age at time of attempt: _____

_____

_ Has anyone in your family ever attempted suicide? _____ If yes please list relationship:_____ Has anyone in your family ever completed suicide? _____ If yes please list relationship:_____ Has anyone else in your life ever attempted or completed suicide? _____ Relationship: _____

Do you currently or have you ever had trouble sleeping? _____ If yes, please describe:

_____

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_____

_ Do you currently or have you ever had problems with eating or with food? _____ If yes, please describe:

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Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:

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_ Spiritual Information

Have you ever or do you currently engage in a personal faith practice: _____ If yes please describe:

_____

_____

_ Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.? _____

If yes, please describe your current level of connection and involvement:

_____

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_____

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Do you want to incorporate your faith/spirituality into the counseling process? _____ If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction:

_____

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_____

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Relationship Information

Are you currently in a relationship? _____ If yes, please list status:_____

Name of Person: _____ Length of time you have known each other:_____

Length of time you have been together: _____Do you currently live together?_____

Number of marriages: _____ Number of divorces: _____ If widowed, your age at death of spouse:_____

Do you have children? _____ If yes, please list below:

Name_____ Age_____ Lives with you_____

Name_____ Age_____ Lives with you_____

Name_____ Age_____ Lives with you_____

If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties you would like to address in individual counseling, please briefly describe:

_____

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_____

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_____

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_____

_ Other persons living in your household and your relationship to them:

_____

_____

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_____

_ **Family Information**

Were you adopted? _____ If yes, your age at time of adoption: _____ With whom did you live until the age of 18? _____ Did your parents ever divorce? _____ If yes, your age at time of divorce: _____ If divorced, did your parents ever re-marry? _____ If yes, list parent(s) and your age(s) at time of re-marriage: _____

_____

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Were you ever in foster care or residential care? _____ If yes, please list age and living situation:

_____

_

_____

_ Mother's current age: _____ If deceased, her age at death: _____ Your age at time of her death: _____ Father's current age: _____ If deceased, his age at death: _____ Your age at time of his death: _____ Do you have siblings? _____ If yes, please list names, ages, and relationship:

_____

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_____

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_____

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Have you ever experienced the death of a family member or a close friend? _____ If yes please list relationship and your age at time of their death:

_____

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_____

_ Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s): ***There is extra room at the end to write/explain further if you wish.***

Event	**Self**	**Other** ***(Relationship?)***
Emotional Abuse		
Legal Problems		
Physical Abuse		
Sexual Abuse		
Homelessness		
Frequent/Multiple Moves		
Domestic Violence		
Accident or Injury		
Financial Problems		

Neglect		
Lived over-seas		
Substance Abuse		
Military member		
Serious Illness		
Discrimination		
Other		

Educational Information

Number of years of education completed: _____ Degree(s) achieved (please circle all that apply): High School Diploma G.E.D. Vocational/Trade School Certificate
Associates Degree Bachelor's Degree Master's Degree Doctorate Degree
Other_____

Vocational Information

Are you currently employed? _____ If yes, please list position title, name of employer, type of work, and length of time at employment: _____
If you are not currently working, how long have you been un-employed? _____
What types of jobs have you typically held? _____
What is the longest period of time you have ever worked at one job? _____
Are you considering a change in job or career? _____ If yes, what type of work are you interested in doing?

_____

_____

Have you ever served in the military? _____ If yes, please list branch, rank, and current status (active/discharged):_____
If you have experienced a deployment, please list approximate dates and length of separation:

_____

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_____

_____

Please list your personal hobbies and interests:

_____

_____

_____

Legal Information Have you ever been the victim of a crime?____ If yes, please list date and briefly describe:

_____

_____

_____

Are you currently involved in divorce or child custody proceedings? _____ If yes, please explain:

Have you ever been convicted of a misdemeanor or felony? _____ If yes, please explain:

Please detail any further information pertinent to your services at Dialectical Counseling & Consulting Group: