Resilient Families Counseling, LLC

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Adult Intake Form

Client Information:

Name: _____ Birthdate: _____Age: _____Sex: M F
Address: _____
Email Address: _____

Telephone: (H)_____(C)_____(W) _____

Which of these may we use to contact you (circle)? Home, Work, Cell, Text Message, Email
At which of these may we leave a message (circle)? Home, Work, Cell

Occupation:_____ Hrs/wk:_____ Do you find this work satisfying?_____

Religion:_____ Active: Y/N Place of Worship:_____

Presently living with:	Marital Status:	Highest Education Completed:
Parent(s) _____	Single _____	Elementary _____
Spouse _____	Married _____(yrs.)	High School _____
Children _____	Divorced _____ (yrs.)	College_____
Other _____	Other _____	Other _____

How did you hear about us? _____

May we contact this person to thank them for the referral? Yes____No____Not Applicable_____

Emergency Contact: _____Phone: _____

Spouse Information:

Spouse's Name: _____Birthdate:_____ Age:_____

Address (if different): _____

Email Address:_____

Telephone: (H)_____(C)_____(W) _____

Which of these may we use to contact you (circle)? Home, Work, Cell, Text Message, Email
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Parents _____	Single _____	Elementary _____
Spouse _____	Married _____(yrs.)	High School _____
Other: _____	Divorced _____ (yrs.)	College_____
Other _____	Other _____	Other _____

Current Situation:
Briefly describe the problem that prompted you to seek counseling at this time:

_____

_____

_____

Current Concerns:
Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate each item.

0 1 2 3 4 5 6 7 8 9 10

No concern **Moderate concern** **Extreme concern**

_____ Anger/Temper
_____ Education
_____ Family Problems
_____ Fearfulness
_____ Physical Problems
_____ Problems with Children
_____ Sexual Concerns
_____Thoughts of suicide
_____ Unhappy most of the time
_____ Depression
_____ Anxiety
_____ Use of Drugs or Alcohol
_____ Marital Problems
_____ Problems with Social Relationships
_____ Religious/Spiritual Concerns
_____ Trouble making decisions
_____ Worry
_____ Other (specify):_____

Medical Information:
Please describe any previous counseling/therapy: _____

_____

_____

When did you last consult with your primary care physician? _____

Are you currently receiving medical treatment? Yes_____No_____

Are you currently taking any prescription medication? Yes _____ No_____

Please list your medications here:

Name Dosage For what condition? Who prescribed it?

_____

_____

_

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is

2. I worry about

3. What I do best is

4. Sometimes I feel guilty about

5. What makes me angry is

6. My biggest mistakes were

7. My job

8. What makes me nervous is

9. My personality would be better if

10. I often felt that mother

11. My temper

12. My childhood

13. Prayer is

14. My biggest disappointment

15. To me, sex is

16. I would be better liked if

17. I often felt that father

18. God to me is

19. My children (child)

20. Women are

21. What hurts me most is

22. My biggest problem is

23. Men are