new leaf COUNSELING & COACHING
insight • healing • renewal

ADULT INTAKE

Name: _____ Date: _____

Date of Birth: _____ Age: _____ How were you referred? _____

1. What has brought you in for counseling?

_____
_____
_____

2. What kind of symptoms have you been having?

_____ difficulty sleeping
_____ appetite changes
_____ crying spells
_____ increased anger/irritability
_____ problems at work
_____ social isolation
_____ increased anxiety
_____ panic attacks
_____ problems focusing
_____ increased alcohol/drug use
_____ relationship problems
_____ feeling overwhelmed/stressed

Other symptoms:

_____
_____
_____

3. How long has this been an issue?

_____

4. What have you already tried to do to resolve this issue?

_____
_____

5. Who would you consider your current support system? (family, friends, coworkers, church, etc)

_____
_____

6. What would you say your current coping mechanisms are (good, bad, or neutral)?

_____
_____
_____

7. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use):

_____
_____
_____

8. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain:

_____
_____

9. Who lives with you in your home?

Name and Relationship:	Age:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Medical History:
Briefly describe your general health as well as any chronic conditions

_____
_____
_____

Please list all **current** medications including over-the-counter and prescription medications:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please **prior** medication for mental health issues, chemical dependency or alcohol use:

Name of Medication:	Dosage:	Date Stopped:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Legal History:
Please place an **"N"** for none, **"C"** for currently experiencing or **"P"** for experienced in the past.
DUI _____ Bankruptcy _____ Divorce _____ Unemployment _____
Domestic Violence _____ Custody Dispute _____ Disability Claim _____ Workman's Comp _____
Other: _____ Please explain: _____

12. Are you currently experiencing any financial problems?

_____

13. Educational Background (highest grade completed/degree): _____

14. Current Employment (Please describe current job briefly, including how long you've worked there):

_____
_____

15. Feelings about your job:

_____

16. Military Service:_____

17. History of Abuse:
Please place an **"N"** for none, **"C"** for currently experiencing or **"P"** for experienced in the past.

Verbal Abuse _____	Emotional Abuse _____	Childhood Abuse _____
Physical Abuse _____	Spousal Abuse _____	Sexual Abuse _____

Briefly explain:

_____
_____
_____

18. Alcohol and Drug Use:
Do you drink alcohol? Yes____ No_____ If yes, how often?_____
When was the last time you had a drink? _____
How much did you drink at that time? _____
Do you have any history of using or abusing drugs/medications? Yes____ No____
Do you currently abuse any drugs/medications? Yes____ No____
What substances have you used in the last 6 months? (check all that apply)
[ ] Marijuana [ ] Cocaine [ ] Inhalants/ "Huffing" [ ] LSD/ "Acid" [ ] Amphetamines/ "Speed"
[ ] Other [ ] Pain Killers [ ] Sedatives/ "Downers" [ ] None of Above

If "Other" is checked, explain below:

_____

19. Sexuality:
Are you satisfied with your sex life? Yes_____ No_____
(If not, please explain)

_____
_____

20. Religion/Spirituality:
Do you have an identified religious or spiritual preference? If so, how do you practice/use it?

_____
_____

21. Harm to Self or Others:

Do you currently have any urges/thoughts of hurting yourself?	Yes_____ No_____
Any current urges/thoughts of hurting someone else?	Yes_____ No_____
Any history of hurting self or suicide attempt?	Yes_____ No_____
Any history of physical aggression toward another	Yes_____ No_____

If yes on any of these questions, please describe in the space below:

_____
_____

22. What kinds of things would you ultimately like to see improve or change, as a result of this therapy?

_____
_____
_____
_____