Calvary Community Counseling - Adult Intake Document

Name: _____ Today's date: _____/_____/_____

Home phone: _____Cell: _____

Date of birth: _____/_____/_____ Age: _____ Email: _____

Address: _____

Family Information

Marital Status (check ALL that apply): Single • Never married • Exclusively dating • Cohabitating
☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed

Names and ages of children: _____

Have you ever adopted or served as a foster parent? _____

Who lives with you? _____

Education and Work

What is your highest level of education? _____ Currently in school? _____

What is your current occupation? _____ Approx. yearly salary: _____

Years at current job: _____Hours working per week: _____ Level of job satisfaction: _____

History of incarceration or legal issues: _____

Lifestyle

Describe level of physical exercise: _____

Describe the average quantity and quality of your sleep: _____

_____

Describe any allergies or dietary restrictions: _____

How often do you typically drink alcohol in a month? _____ How many drinks per occasion? _____

How do you feel about your current level of alcohol consumption? _____

Describe your daily nicotine use (smoking/vaping): _____

Describe your daily caffeine intake: _____

Describe any past and/or present illicit drug use: _____

_____

Have you ever been criticized for your drinking or drug use? _____

Brief Confidential Medical History

Name of medical doctor: _____ Phone number: _____

Approximately when was your last medical exam/checkup? _____/_____/_____

Briefly describe your past and present medical history: _____

_____

List ALL current medication: _____

_____

Describe any historical hospitalizations that lasted 3+ days: _____

Do you have a history of seizures? _____

How many times have you suffered a head injury and/or lost consciousness? _____ Briefly explain:

_____

☑ Check those that apply to *you*. Underline those that apply to *immediate family members*:

☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ Schizophrenia ☐ Autism ☐ Learning Disorders

☐ ADHD ☐ Suicidal thoughts ☐ Suicide attempt ☐ Suicide completion of relative

☐ Substance abuse ☐ Physical or sexual abuse ☐ Eating disorder ☐ Sleep disorders

☐ Chronic illness ☐ Accidental or untimely death of relative ☐ Other: _____

Previous mental/emotional/behavioral health treatment (if applicable):

Therapist/hospital	Approx. start and end date	Frequency (weekly?)/ intensity (inpatient?)	Issue(s) addressed	Results/ frustrations

Describe anything else you would like your counselor to know about your history:

Moving Forward

Briefly describe your religious affiliations / faith journey / beliefs: _____

_____

_____

Who do you turn to for social support (encouragement, advice, friendship, etc.)? _____

_____

Describe your level of motivation/desire to change something: _____

_____

Your goals/issues to address in counseling: (☑ Check the boxes for any and ALL that apply.)

_ ☐ Depressed moods	_ ☐ Anger/ management issues	_ ☐ Compulsions and/or obsessions
_ ☐ Anxiety	_ ☐ Spiritual problems	_ ☐ Relational conflict (family/friends)
_ ☐ Social difficulties	_ ☐ Child: mood/anxiety problems	_ ☐ Sexual intimacy concerns
_ ☐ Stress management	_ ☐ Child: social problems	_ ☐ Communication problems
_ ☐ Legal concerns	_ ☐ Child: behavioral problems	_ ☐ Substance abuse (alcohol/drugs)
_ ☐ Premarital counseling	_ ☐ Child: academic problems	_ ☐ Other addictions (porn/shopping/sex)
_ ☐ Community problems	_ ☐ Emotional/sexual infidelity	_ ☐ Other marital/relationship concerns
_ ☐ Eating disorders	_ ☐ Unresolved past issues	_ ☐ Custody concerns
_ ☐ Family conflict	_ ☐ Loneliness	_ ☐ Parent-adult child concerns
_ ☐ Parenting issues	_ ☐ Impulsive decision-making	_ ☐ Pre-separation/divorce/breakup
_ ☐ Blended family issues	_ ☐ Unwanted sexual experiences	_ ☐ Conflict management
_ ☐ Work problems	_ ☐ Educational/career concerns	_ ☐ Life adjustment issues
_ ☐ Financial concerns	_ ☐ Self-esteem/confidence	_ ☐ Intrusive memories/triggers
_ ☐ Medical/health issues	_ ☐ Unprocessed losses	_ ☐ Self-harm behaviors (cutting/drugs)
_ ☐ Gambling difficulties	_ ☐ Domestic violence or abuse	_ ☐ Struggle with feelings of shame
_ ☐ Sleep disturbances	_ ☐ Weight management	_ ☐ Bereavement/grief/loss
_ ☐ Other: _____		

*Now, using the small blank provided, please go back and identify your top 7 issues to address.
(i.e., the ONE issue ranked as #1 is your highest priority to address in counseling, #2 is the second, etc.)

Please rate how much you have experienced each symptom within the last 2-4 weeks.
(0=none or N/A, 1=a little, 2=moderate, 3=a lot, 4=extreme). You may offer comments to the right.

Relationship with Spouse or Significant Other	Not talking to each other	0	
	Having bad arguments	0	
	Lack of Trust between us	0	
	Feeling lonely in the relationship	0	
	Lack of affection and caring between us	0	
	Feeling unhappy about our relationship	0	
General Symptoms	Feeling sad, down, despondent, or depressed	0	
	Avoiding certain people or places	0	
	Loss of interest in activity normally enjoyed	0	
	Low energy / Feeling tired	0	
	Sleep problem: insomnia, not staying asleep	0	
	Eating too much or too little	0	
	Not able to think clearly	0	
	Feeling no pleasure in life	0	
	Anxiety, Worry, OR Panic related issues	0	
	Complicated relationship issues	0	
	Anger issues	0	
	Lower self-esteem or lower self confidence	0	
	Guilt and/or Shameful feelings	0	
	Stress related feelings	0	
	Thoughts about suicide	0	
	Drinking too much or abusing drugs / meds	0	
	Acting out & other compulsive behaviors	0	
	Not getting tasks / work done	0	
	Feeling unhappy with certain aspects of life	0	
	Spiritual struggles	0	