DATE:

ADULT CLIENT - INTAKE FORM

CLIENT INFORMATION

Name:____

Address:____

Phone: (H)____________________ (C)____________________

Email:____________________ DOB:____________________

Employer:____________________ Occupation:____________________

Do you attend church: Y N If so, where?____________________

Would like you like to incorporate faith into our sessions together? Y N

MEDICAL & PERSONAL INFORMATION

Have you been to a counselor before? Y N Counselor's Name:____________________

Dates To/From:____

Reason for Ending Counseling:____

Are you being seen by a psychiatrist? Y N Psychiatrist's Name:____________________

Primary Care Physician:____________________ Last Visit:____________________

Does any of your immediate family have a history of mental health issues? Y N

Have you been diagnosed with serious medical condition or mental disorders that you would like to discuss in counseling? Y N

Please rate your health: Excellent Good Average Poor

Please list medications that you currently take:____________________

____

DATE:

Circle your relationship status: Single Married Widowed Divorced Separated Remarried

What is your highest level of education?______________________________

Who referred you to Baton Rouge Counseling Associates?______________________________

EMERGENCY CONTACT INFORMATION

Name:______________________________ Phone:______________________________

Address:______________________________

Relationship to Self:______________________________

FAMILY COMPOSITION

Who lives in the same household as you (please include names, ages, & relationship)?

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS

Describe your reason(s) for seeking counseling today:______________________________

____

____

What are three words you would use to describe yourself?______________________________

____

How do you handle stress?______________________________

____

What would you like to gain from counseling?______________________________

DATE:

____

Please circle any of the following that you have experienced in the past 12 months:

Loss of Parent, Family Member, or Close Friend

Divorce/Break Up

Separation

Personal Illness or Injury

Change in Family Member's Health

Pregnancy

Sexual Abuse

Physical Abuse

Outstanding Personal Achievement

Change in Living Conditions

Change in Work Hours

Change in Recreational Habits/Friends

Change is Sleeping/Eating Habits

Problems at School/Work

Legal Problems

Anxiety

Depression

Irritability

Mood Swings

Relational Conflict

Communication Issues

Identity Issues

Low Self Esteem

Suicidal Thoughts

Substance Use/Abuse

Please include any other important information to you medical social, or emotional history:

____

____

____

DECLARATION OF PRACTICES AND PROCEDURES

I, the responsible party (the undersigned), acknowledge that I/we have read a copy of the "Declaration of Practices and Procedures" issued by the counselor at Baton Rouge Counseling Associates.

Client Signature:______________________________________ Date:____________

Counselor Signature:____________________________________ Date:____________