**Mental Clarity Counseling Adult Intake Form**

Please complete as much of this form as you can. Bring the form to your first session.

This information is vital to the treatment process.

# Your information

Name Age Date of birth

*Month/Day/Year*

Referred by Emergency contact name

Relationship to emergency contact Phone ( )

**To be completed by therapist:**

MR#: Account #: Date of service: People present at the initial interview:

*(Name and relationship)*

🞎 Reviewed intake form and referral information.

🞎 Client verbalizes understanding of informed consent and privacy policies.

🞎 Completed release of information as indicated.

* **Is there a phone number where your therapist can leave you a *detailed* message?** 🞎 yes 🞎 no If yes, what is the number?

# Present concerns

What has led you to seek help at this time?

Have you already tried to resolve these concerns? If so, what did you do and how did it work?

Who do you go to for support (family, friends, faith or spirituality, support or self-help groups)?

 **Initials of client\_\_\_\_\_\_\_\_\_\_**

What strengths or resources do you have that will help you succeed in counseling? (Examples include commitment, strong family support, intelligence, good social support, church, friends, etc.)

What might prevent your success in counseling? (Examples include few friends, financial stress, lack of social support, lack of family support, etc.)

# Social History

Please check the item that best describes you below:

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Single | 🞎 Married | 🞎 Remarried | 🞎 Partner or significant other |
| 🞎 Separated | 🞎 Divorced | 🞎 Widowed | 🞎 Other  |

Please describe your living situation. Check all that apply:

|  |  |  |
| --- | --- | --- |
| 🞎 With spouse | 🞎 With partner or significant other | 🞎 With children 🞎 With parents |
| 🞎 Alone | 🞎 With roommate | 🞎 Other  |

Please tell us if you are working. Check all that apply:

🞎 Employed 🞎 Unemployed 🞎 Full-time parent 🞎 Volunteer or other

If you work outside the home (in a paying job or as a volunteer), describe the job and how long you have held it:

Which of the following best describes you? *(Optional)*

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 African | 🞎 African American | 🞎 Asian | 🞎 Hawaiian or Pacific Islander |
| 🞎 Latino/Latina | 🞎 Native American | 🞎 Bi-racial | 🞎 White 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Tell us about your childhood:

Where did you grow up?

Were your parents always married, or was there a divorce?

If they divorced, how old were you at the time?

How many siblings do you have? What was your birth order?

**Initials of client\_\_\_\_\_\_\_\_**

How would you describe your childhood?

Tell us about your current family. Please list the members of your family and household below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Living in same house? (circle)** |
|  |  |  | Yes No |
|  |  |  | Yes No |
|  |  |  | Yes No |

How would you describe relationships in your current family?

Tell us about any other marriages or committed relationships you have had.

Length of relationships:

Do you have children from other relationships? 🞎 yes 🞎 no

If yes, give names and ages (unless already named above):

# Legal status

Have you ever been involved with the legal system (child custody, order for protection, DWI, etc.)?

🞎 yes 🞎 no

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Education

Please list the highest grade you have completed:

Do you have learning problems in any of these areas? 🞎 Speech 🞎 Hearing

🞎 Reading 🞎 Writing 🞎 Concentration 🞎 Attention 🞎 Other:

**Initials of client\_\_\_\_\_\_\_\_**

If you have problem areas or a preferred way to learn, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_
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# Ethnicity, culture and religion

Please share any ethnic, cultural or religious concerns that may be helpful to your therapist:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is English your preferred language? 🞎 yes 🞎 no

If no, list language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like an interpreter or other support involved in your therapy? 🞎 yes 🞎 no

# Mental health and chemical dependency in your family of origin

Please list any relatives (blood relatives) who have had mental health issues.

Depression:

Bipolar/manic depression:

Anxiety (panic attacks, obsessive-compulsive disorder, phobias):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating disorders: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug or alcohol abuse or dependence: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attention deficit disorder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Your mental health and chemical dependency history

Have you ever had therapy, counseling, hospital treatment or medicines for:

 Mental health problems? 🞎 yes 🞎 no

 Chemical dependency? 🞎 yes 🞎 no

 **Initials of client\_\_\_\_\_\_**

If yes, when, where and what was being treated?

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Treated For** | **Treatment Type***(hospital, medicine, counseling)* | **Provider or Location of Care** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

~~·~~Please complete the following.

1. In the past year, have you felt you ought to cut down on your drinking or drug use? 🞎 yes 🞎 no
2. In the past year, have you had people annoy you by criticizing your drinking or drug use? 🞎 yes 🞎 no
3. In the past year, have you felt bad or guilty about your drinking or drug use? 🞎 yes 🞎 no
4. In the past year, have you had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, to get rid of a hangover or to get the day started? 🞎 yes 🞎 no

Please describe your current use of the following.

|  |  |  |
| --- | --- | --- |
| *Yes*🞎 | *No*🞎 | **Alcohol** times per day / week / month / year *(circle one)*. |
|  |  | How much at a time? When did you first start using it?  |
| 🞎 | 🞎 | **Tobacco** times per day / week / month / year *(circle one)*.How much at a time? When did you first start using it?  |
| 🞎 | 🞎 | **Caffeine** times per day / week / month / year *(circle one)*.How much at a time? When did you first start using it?  |
| 🞎 | 🞎 | **Marijuana** times per day / week / month / year *(circle one)*.How much at a time? When did you first start using it?  |
| 🞎 | 🞎 | **Other: ,** times per day / week / month / year *(circle one)*.How much at a time? When did you first start using it?  |
| 🞎 | 🞎 | **Use of prescription or over-the-counter medicines** timesper day / week / month / year *(circle one)*. How much at a time? When did you first start using it?  |

List any problems you have had because of drinking or drug use (with friends, the law, your money, your job, sex, school, family):

***For therapist only – Do not write in this area:***

🞎 Therapist discussed general effects of chemical use on health and well-being.

🞎 Client given fact sheet discussing general effects of chemicals on health and well-being.

# Trauma and abuse history

Describe any major losses you have had (such as death, disability, divorce, relationship changes):

Describe any trauma or abuse in your life (such as physical, sexual or emotional abuse; assault; neglect; domestic violence; witnessing the abuse of another, etc.):

Physical abuse

Sexual abuse

Emotional abuse

Neglect

Assault

Military-related trauma or distress

Discrimination:

Other

# Safety concerns

Have you ever **thought about** hurting or killing yourself, or had an impulse to do so?

🞎 yes 🞎 no If yes, do you have a suicide plan? 🞎 yes 🞎 no

 If so, please explain:

Have you ever **tried** to hurt or kill yourself? 🞎 yes 🞎 no

 If yes, list the date and method:

­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever harmed property or other people, or thought about causing harm? 🞎 yes 🞎 no

 If yes, please explain:

To your knowledge, are there firearms in your home? 🞎 yes 🞎 no

If known, how many and of what type (pistol, revolver, rifle, automatic)?

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Do children or teens have access to these firearms? 🞎 yes 🞎 no

 **Initials of client** \_\_\_\_\_\_

Are these firearms stored unloaded and locked with trigger guards?

 🞎 yes 🞎 no (You can get trigger guards free of charge from the local police dept.)

Is the ammunition (bullets) kept in a separate location? 🞎 yes 🞎 no

**Medical status** (attach another page, if needed)

Do you have a primary care clinic or doctor? 🞎 yes 🞎 no

Name of clinic or doctor

Phone ( ) Fax ( )

Have you had a physical exam to check for medical reasons for your symptoms?

🞎 yes 🞎 no Date of your last physical exam

Do you have a psychiatrist? 🞎 yes 🞎 no

Name of psychiatrist

Phone ( ) Fax ( ) Date of last visit:

Have you ever had any major medical problems? 🞎 yes 🞎 no

If yes, please explain:

Do you currently have any physical pain? 🞎 yes 🞎 no

If yes, please explain:

Is your pain constant or chronic (recurring or ongoing)?

🞎 yes 🞎 no

Please circle your pain level below:

#  0 2 4 6 8 10

## No pain Mild pain Moderate pain Severe pain Extreme pain As bad

**as it could be**

Are you concerned about your weight or eating habits? 🞎 yes 🞎 no

Are other people concerned? 🞎 yes 🞎 no

If yes to either question, please explain:

**Initials of client**\_\_\_\_\_\_\_\_

Are you taking any medicines (prescribed or over-the-counter) or herbal products? 🞎 yes 🞎 no

## If yes, please list these below.

**Medication Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | EXAMPLE | Medicine#1 | Medicine#2 | Medicine#3 | Medicine#4 | Medicine#5 | Medicine#6 |
| Name of medicine | Celexa |  |  |  |  |  |  |
| How many milligrams (mg)? | 40 mg |  |  |  |  |  |  |
| How many pills do you take at a time? | one |  |  |  |  |  |  |
| How many times a day do you take this medicine? | once |  |  |  |  |  |  |
| What time of day do you take this medicine? | morning |  |  |  |  |  |  |
| What does this medicine treat? | depression |  |  |  |  |  |  |
| Name of prescribing doctor | Dr. John Doctor |  |  |  |  |  |  |

##

## If you need more space, please attach another sheet of paper.

Do you have any allergies? 🞎 yes 🞎 no

Have you ever had a bad reaction to medicine? 🞎 yes 🞎 no

If yes to either question, please describe:

## Client signature:

D**ate:**

Time:

# Please check off and explain any symptoms you are having

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms or stressors** | **When did it start?** | **How often does it happen?** | **Therapist notes *(note mild, moderate or severe)*** |
| 🞎 | Compulsive behavior (too much hand washing, checking, TV, spending) |  |  |  |
| 🞎 | Grief(job loss, death, health ) |  |  |  |
| 🞎 | Relationship problems |  |  |  |
| 🞎 | Sexual issues (orientation, identity, function) |  |  |  |
| 🞎 | Financial issues |  |  |  |
| 🞎 | Racing thoughts |  |  |  |
| 🞎 | Trouble making decisions |  |  |  |
| 🞎 | Impulsive behavior |  |  |  |
| 🞎 | Nightmares |  |  |  |
| 🞎 | Muscle tension or headaches |  |  |  |
| 🞎 | Feeling shaky |  |  |  |

Client signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by therapist (signature and credentials):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_