Abundant Life
COUNSELING SERVICES, P.A.

ADULT INTAKE FORM

Thank you for choosing Abundant Life Counseling Services, P.A. To better assist you, please fill out this form as fully and openly as possible. All information is held in strictest confidence within legal limits. If certain questions do not apply to you, please leave them blank.

IDENTIFYING INFORMATION

Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

Date of Birth _____Age _____ Male _____Female _____

Occupation _____

Religion_____

May we call you at your home? Yes _____ No _____

May we call you at your office? Yes _____ No _____

May we call you on your cell phone? Yes _____ No _____

May we leave a message at home? _____ Office? _____ Cell? _____

Email address _____

CURRENT MARITAL INFORMATION

Never Married _____ Married _____ Divorced _____ Separated _____ Widowed _____

Name of Spouse _____ Date of Marriage _____

Spouse's address (if different from yours):

Street _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

Date of Birth _____Age _____ Male _____Female _____

Occupation _____

Religion_____

Is spouse willing to come in for counseling? Yes _____ No _____ Unsure _____

Have you ever separated from your current spouse? Yes _____ No _____ When? _____

Have either of you filed for divorce? Yes _____ No _____ When? _____

Age when married: Husband _____ Wife _____

How long did you know your spouse before marriage? _____

Length of steady dating with spouse? _____ Length of engagement? _____

PREVIOUS MARITAL HISTORY

Self

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death

Spouse

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death

Your Education:

GED _____ High School Diploma _____ College Degree _____ Graduate Degree _____

Degree(s) held: _____

Any coursework related to Mental Health or Psychology? If yes, describe briefly: _____

_____

Spouse's Education:

GED _____ High School Diploma _____ College Degree _____ Graduate Degree _____

Degree(s) held: _____

Any coursework related to Mental Health or Psychology? If yes, describe briefly: _____

_____

Children:

Child's Name	Age	Gender	Father's/Mother's First Name

PERSONAL INFORMATION

Are religious or spiritual issues important in your life? Yes _____ No _____

Are you currently attending a church? Yes _____ No _____

What is your denomination preference? _____

Who referred you to our center? _____

May we acknowledge your referral (your name will be kept confidential)? _____

HEALTH INFORMATION

How would you rate your health? _____

Recent (3 months) weight change: Lost _____ lbs. Gained _____ lbs.

List all important present or past illnesses, injuries or handicaps: _____

_____

How many hours do you sleep each night? _____

Do you experience food cravings? Yes _____ No _____

If so, for what items? _____

How would you rate your diet?

Very Healthy _____ Healthy _____ Average _____ Needs Improvement _____ Poor _____

Are you currently on medications? Yes _____ No _____

If so, please complete the following:

Medication	Dosage	Frequency	Purpose	Physician

Primary care physician _____

Physician's phone number _____

Date of last physical exam _____ Date of last routine checkup _____

Are you currently using any drugs for recreational purposes? Yes _____ No _____

Are you currently consuming alcohol for recreational purposes? Yes _____ No _____

If so, please list the drug(s) and/or alcohol:

Substance	Amount	Frequency

Do you have any current or past legal issues? Yes _____ No _____

If yes, please briefly explain: _____

Have you ever been arrested? Yes _____ No _____

If yes, please briefly explain: _____

Have you recently suffered any personal, business or financial loss? If so, please explain: _____

_____

Have you ever been the victim of a crime? Yes _____ No _____ If so, please explain: _____

_____

Have you ever been abused? Yes _____ No _____ If yes, when? _____

_____

Women:

Are you pregnant? Yes _____ No _____

Do you have a regular menstrual cycle? Yes _____ No _____

Have you ever terminated a pregnancy? Yes _____ No _____

Have you ever miscarried? Yes _____ No _____

PERSONAL CONCERNS

What are you seeking help for? _____

_____

_____

How much are you troubled by this?

Constantly _____ Often _____ Somewhat _____ Not very much _____

Comments concerning this problem:

_____

_____

Have you been in counseling before? If so, for each incidence you remember, please complete the following (use the back of this page if needed):

1. Who was the counselor? _____

What was the problem? _____

How many sessions, over what period of time? _____

What were the results? _____

2. Who was the counselor? _____

What was the problem? _____

How many sessions, over what period of time? _____

What were the results? _____

3. Who was the counselor? _____

What was the problem? _____

How many sessions, over what period of time? _____

What were the results? _____

Have you ever filed a complaint against a mental health professional? Yes _____ No _____

If so, please explain: _____

_____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless. Never ____ Rarely ____ Sometimes ____ Frequently ____
2. I am lonely. Never ____ Rarely ____ Sometimes ____ Frequently ____
3. No one cares about me. Never ____ Rarely ____ Sometimes ____ Frequently ____
4. I am a failure. Never ____ Rarely ____ Sometimes ____ Frequently ____
5. Most people don't like me. Never ____ Rarely ____ Sometimes ____ Frequently ____

6. I want to die. Never ____ Rarely ____ Sometimes ____ Frequently ____
7. I want to hurt someone. Never ____ Rarely ____ Sometimes ____ Frequently ____
8. I am so stupid. Never ____ Rarely ____ Sometimes ____ Frequently ____
9. I am going crazy. Never ____ Rarely ____ Sometimes ____ Frequently ____
10. I can't concentrate. Never ____ Rarely ____ Sometimes ____ Frequently ____

11. I am so depressed. Never ____ Rarely ____ Sometimes ____ Frequently ____
12. God is disappointed. Never ____ Rarely ____ Sometimes ____ Frequently ____
13. I can't be forgiven. Never ____ Rarely ____ Sometimes ____ Frequently ____
14. Why am I so different? Never ____ Rarely ____ Sometimes ____ Frequently ____
15. I can't do anything right. Never ____ Rarely ____ Sometimes ____ Frequently ____

16. People hear my thoughts. Never ____ Rarely ____ Sometimes ____ Frequently ____
17. I have no emotions. Never ____ Rarely ____ Sometimes ____ Frequently ____
18. Someone is watching me. Never ____ Rarely ____ Sometimes ____ Frequently ____
19. I hear voices in my head. Never ____ Rarely ____ Sometimes ____ Frequently ____
20. I am out of control. Never ____ Rarely ____ Sometimes ____ Frequently ____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts

that occur frequently or are of concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

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_____

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_____

SYMPTOMS

Please check the behaviors and symptoms that occur more often than you would like:

_____ Aggression
_____ Alcohol Dependence
_____ Anger
_____ Antisocial Behavior
_____ Anxiety
_____ Avoiding People
_____ Chest Pain
_____ Depression
_____ Disorientation
_____ Distractibility
_____ Dizziness
_____ Drug Dependence
_____ Eating Disorder
_____ Elevated Mood
_____ Fatigue
_____ Hallucinations
_____ Heart Palpitations
_____ High Blood Pressure
_____ Hopelessness
_____ Impulsivity
_____ Irritability
_____ Judgment Errors
_____ Loneliness
_____ Memory Impairment
_____ Mood Shifts
_____ Panic Attacks
_____ Phobias/Fears
_____ Recurring Thoughts
_____ Sexual Difficulties
_____ Sick Often
_____ Sleeping Problems
_____ Speech Problems
_____ Suicidal Thoughts
_____ Thoughts Disorganized
_____ Trembling
_____ Worrying
_____ Withdrawing
_____ Other (Please specify)
_____
_____
_____
_____
_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (i.e., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____

_____

_____

_____

SPECIFIC PROBLEM AREAS

Please check any of the following that are currently troubling you:

_____ Abortion
_____ Abandonment issues
_____ Adoption
_____ Addiction(s)
_____ Alcoholism
_____ Anger
_____ Anxiety
_____ Apathy
_____ Bitterness/Resentment

_____ Burnout/Stress
_____ Change of Lifestyle
_____ Child Abuse
_____ Children/Discipline
_____ Children/School
_____ Children/Rebellion
_____ Communication
_____ Confusion
_____ Crisis/Conflict
_____ Death of Loved One
_____ Depression
_____ Divorce
_____ Eating Disorder
_____ Envy/Jealousy
_____ Family Issues
_____ Father Issues
_____ Fear of Rejection
_____ Fear (general)
_____ Finances/Debt
_____ Forgiveness
_____ Frustration
_____ Gambling
_____ Guilt
_____ Health/Medical
_____ Honesty
_____ Infidelity
_____ In-Laws
_____ Job Problems
_____ Legal Issues
_____ Loneliness
_____ Loss of Appetite
_____ Loss of Control
_____ Loss of Concentration
_____ Loss of Energy
_____ Loss of Memory
_____ Loss of Sleep
_____ Loss of Temper
_____ Loss of Trust
_____ Marriage
_____ Medication/Drugs
_____ Mid-life
_____ Mother Issues
_____ Obsessive Thoughts
_____ Obsessive Actions
_____ Panic Attacks
_____ Physical Abuse
_____ Pornography Use
_____ PMS/Hormones
_____ Religion/Faith Issues
_____ Same-Sex Attraction
_____ Self-Injury (cutting, burning, etc.)
_____ Separation
_____ Sexual Abuse/Rape
_____ Sexual Addiction
_____ Sexual Compulsion
_____ Sexual Issues (other)
_____ Single Parent
_____ Singleness
_____ Spouse Abuse
_____ Substance Abuse
_____ Suicidal Thoughts
_____ Self-Esteem
_____ Rejection
_____ Violence/Rage
_____ Withdrawal
_____ Worry
_____ Other (please list below)

Other specific areas of concern:

_____

_____

_____

_____

Of the above, please circle your top three areas of current concern. How long have these problems existed? _____

_____

_____

Indicate everything that you have experienced in the past three years:

☐ Death of a spouse/partner/friend
☐ Marriage problems
☐ Changes in marital status
☐ Death of a family member
☐ Family problems
☐ Loss of job
☐ Major illness or injury (self)
☐ Major illness or injury (family)
☐ Financial Problems
☐ Legal Problems
☐ Move to another city or state

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____