

**Hardy & Stephens Counseling Associates
Adult Intake Form**

Name: _____

What is bringing you to counseling at this time?

What areas of your life do you feel are impacted by this problem/issue?

Work Home Peers Family Neighbors

Siblings Parents Relatives Other

Family History:

Family Constellation (who is in your family):

Name	Age	Gender	Relationship	Ethnicity	Location

Current Living Situation (who do you live with):

Family History

Please describe your family history, including any losses:

Employment

Where do you work?

Length of employment:

Describe your feelings about your job:

Education

What is the highest degree you have received?

School(s) attended:

Do you have a history of learning disability or special education services?

Legal History

Please list any legal issues (past or present):

Religious Background

What is your religious preference (denomination)?

How important is your faith/religion in your life?

Relationship History

Please list significant relationship history (engagements, divorces, etc.)

Mental Health History

Please indicate if you have a history of any of the following:

Sexual Abuse	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> No history
Physical Abuse	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> No history
Suicide Attempt	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> No history
Self Injury (cutting, burning, etc.)	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> No history
Violent behaviors	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> No history

Psychological History

Have you been in counseling before? How long?

Was counseling beneficial to you?

Please list any previous counseling, treatment or mental health related hospitalizations (include therapist, date, location and for what):

Please list any family history of mental health concerns (depression, anxiety, etc.):

Current and Past Chemical Use:

Do you drink alcoholic beverages? No Yes If yes, what do you drink? Beer Wine Hard Liquor

How often do you drink? Daily 3-5times weekly 1-2 times weekly Less frequently

Do you sometimes drink more than you had planned? No Yes

Have family or friends ever expressed concern about your drinking? No Yes

Have you ever been arrested for alcohol related charges: DWI, public intoxication, etc? No Yes

Have you ever been treated for drinking or gone to AA? No Yes

Have you ever had episodes where you were unable to remember periods when you were drinking? No Yes

What has been your experience with the following?	Use currently	Used in past	Never used
Tranquilizers: valium librium azene milltown equanil xanax centrax			
Pain Pills/Narcotics: darvon codeine percodan demerol dilaudid heroin talwin			
Stimulants: amphetamines speed dexedrine ritalin white crosses zip cocaine & derivatives crack, crank methamphetamine			
Sleeping Pills/Soporifics: doriden placidyl dalmane seconal tuinal nembutal amytal phenobarbital noctec somnos			
Hallucinogens: marijuana hashish THC LSD Mescaline psilocybin MDA PCP Angel Dust Mushrooms			
Volatiles: Aerosols paint thinner glue lacquer amyl or butyl white "poppers" gasoline			
Others (please list):			

Have family or friends ever expressed concern over your use of drugs? No Yes

Have you ever been arrested for any offense involving drugs? No Yes

Have you ever been treated for chemical dependency? No Yes

Have you ever overdosed on drugs (accidental or purposeful)? No Yes

Do you have a family history of chemical dependency/alcoholism?

Medical History

Do you have any significant medical concerns or is there any significant family medical history (include allergies, infectious diseases & relevant medical concerns)?

Please list all medications you are currently taking:

Medication	Dosage	Prescribing Physician

Primary Care Physician:

May we contact them?

Clinic:

Address and Phone:

What would you describe as your strengths?

What are your vulnerabilities?

Is there anything else you think would be important for us to know in helping you?

