HARP Christian Counseling, Inc.

Adult Intake Information

Client's Name: _____ Date: _____

Gender: ___F ___ M Date of Birth: _____ Age: _____

Form Completed by (if someone other than client): _____

Primary reason(s) for seeking services:

___ Marital Problems	___ Parenting	___ Relationship	___ Family
___ Anger management	___ Anxiety	___ Coping	___ Depression
___ Eating disorder	___ Fear/Phobias	___ Mental confusion	___ Sexual concerns
___ Sleeping problems	___ Alcohol/drugs	___ Eating habits	___ Job
___ Addictive behaviors	___ Medical/Health problems		

Other mental health concerns (specify): _____

*If you need any more space for any of the questions, please use the back of the sheet.

Marital Status

(more than one answer may apply)

___ Single	___ Divorce in process Length of time: _____	___ Unmarried, living together Length of time: _____
___ Legally married Length of time: _____	___ Separated Length of time: _____	___ Divorced Length of time: _____
___ Widowed Length of time: _____	___ Annulment Length of time: _____	Total # of marriages: _____

Religious/Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ___ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Would you like your spiritual/religious beliefs incorporated into your counseling? ___Yes ___ No

If Yes, describe: _____

Do you have a religious affiliation? ___ Yes ___ No

If Yes, please explain: _____

Legal

Are you involved in any criminal proceedings or litigation at this time? ___ Yes ___ No
If Yes, please describe: _____

Are you currently on probation or parole? ___ Yes ___ No
If Yes, please describe: _____

Education

Level of education completed: ___ GED ___ High School ___ Some College ___ Associate
___ Bachelors ___ Masters ___ PhD ___ Other Ex: _____
Currently enrolled in school? ___ Yes ___ No
If Yes, where: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Military

Military experience: ___ Yes ___ No Combat experience: ___ Yes ___ No
Where: _____
Branch: _____ Discharge date: _____
Type of discharge: _____

Family Information

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	_____	_____		_____	
Father	_____	_____	_____		_____	
Spouse	_____	_____	_____		_____	
Children	_____	_____	_____		_____	
	_____	_____	_____		_____	
	_____	_____	_____		_____	
	_____	_____	_____		_____	

Significant others (e.g., brothers, sisters, grandparents, step-relatives. Please specify relationship):

_____

Medical/Physical Health

___ AIDS
___ Alcoholism
___ Abortion
___ Anemia
___ Bladder control
___ Cancer
___ Chronic pain
___ Dizziness
___ Diabetes
___ Drug Abuse
___ Epilepsy
___ Eating problems
___ Fatigue
___ Hepatitis
___ Headaches/Migraines
___ High blood pressure
___ Mononucleosis
___ Miscarriages
___ Nausea
___ Neurological disorders
___ Sexual problems
___ Sleeping disorders
___ Stomach aches
___ Sexually transmitted diseases
___ Thyroid problems
___ Vomiting

Other (describe): _____

List any current health concerns: _____

List any recent health or physical changes: _____

Current Prescribed medications	Dose	Length of time	Purpose	Side effects

Current Over-the-counter meds	Dose	Length of time	Purpose	Side effects

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

___ Sleep patterns
___ Energy level
___ Nervousness/tension
___ Eating disorders
___ Physical activity level
___ Weigh gain/loss
___ Behavior
___ General disposition

Describe changes in areas in which you check above: _____

_____

Prior Counseling History

Please tell us about your prior counseling and/or treatment history:

	Yes	No	When	Where	Reason/Diagnosis
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Have any of your family members or significant others had counseling or treatment in any of the above areas? If Yes, please explain: _____

_____

Do you drink alcohol? ___ Yes ___ No If so, how often and in what quantity? _____

Have you used/abused drugs, alcohol or controlled substances? ___ Yes ___ No
If Yes, please explain: _____

_____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?
If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs/alcohol? ___Yes ___No
If Yes, describe: _____

Have drugs or alcohol created a problem for your job/relationship? ___Yes ___ No
If Yes, describe: _____

Behavioral History

Please check behaviors and symptoms that are problematic for you:

___ Aggression
___ Alcohol dependence
___ Anger
___ Hallucinations
___ Anxiety
___ Avoiding people
___ Chronic pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Phobias/fears
___ Fatigue
___ Gambling
___ Sexual addiction
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Hyperactivity
___ Panic Attacks
___ Pornography
___ Disruptive thoughts
___ Spending problems
___ Sexual difficulties
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Disorganized thoughts
___ Trembling
___ Withdrawing
___ Worrying
___ Social problems

Other (specify): _____

Briefly discuss how the above symptoms impact your ability to function: _____

_____

Does anyone in your family have a history of anxiety, depression, or other mental health problems?
___ Yes ___ No If Yes, please explain: _____

Stress Indicators

Were there special, unusual, or traumatic circumstances that affected you in your childhood?
(i.e., car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)
___ Yes ___ No If Yes, please describe: _____

Please check any events that have occurred in the last 12 months:

___ Moving
___ Marriage
___ Natural disaster
___ Divorce
___ Car trouble
___ Job Change
___ Financial Problems
___ Birth/Adoption of a child
___ Death of a close family member/friend

Counseling Goals

What would you like to see accomplished in your counseling?

1. _____

2. _____

3. _____