Client Name: _____ Client ID: _____Date: _____

Adult Intake Assessment

Identifying Information:

Name: Last	First	Middle Initial
Date of Birth:	Gender: ☐ Male ☐ Female	
Insurance Type:	Name and birthdate of primary holder:	
Insurance ID/Number:	Insurance Group Number:	
Age:	Race:	Gender Identity/Sexual Orientation:
Address:		
City:	State:	Zip Code:
Phone:	Emergency Contact:	Phone:
Relationship to Emergency Contact:		

Medical History:

How is your overall health now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please explain any physical problems/health issues that you struggle with:

_____
_____
_____

Additional health issues you have had in the last 30 days:

_____
_____

Client's personal physician:

Name:
Address:
Phone Number:
Date of last doctor's visit:
If you do not have a primary care physician would you like to be referred to one? ☐ Yes ☐ No
Number of emergency room visits in last year:
Number of inpatient hospitalizations in last year:
Do you experience: ☐ fatigue ☐ chest pains ☐ constipation ☐ skin trouble ☐ weight gain ☐ headaches ☐ diarrhea ☐ kidney trouble ☐ fainting ☐ weakness ☐ stomach trouble ☐ dizzy spells ☐ night sweats ☐ ulcers ☐ thyroid trouble ☐ chills ☐ liver disease ☐ sleeping difficulties ☐ loss of appetite ☐ weight loss ☐ none ☐ other:
Have you ever had a positive TB test?: ☐ yes ☐ no ☐ unknown If positive was it active? ☐ yes ☐ no ☐ unknown
Do you smoke?: ☐ yes ☐ no ☐ unknown If yes, how much?
Do you drink? ☐ yes ☐ no ☐ unknown If yes, how much?

Client Name: _____ Client ID: _____Date: _____

Current height: ☐ unknown	Height one year ago: ☐ unknown
Current weight: ☐ unknown	Weight one year ago: ☐ unknown

Have you ever had:

☐ Measles	☐ Meningitis	☐ Lupus	☐ High Blood Pressure	☐ Skin Disease	☐ Bone/joint disease
☐ Polio	☐ Pneumonia	☐ Thyroid Disease	☐ Heart Disease	☐ Arthritis	☐ Cancer – Type:
☐ Mumps	☐ Diphtheria	☐ Epilepsy/Seizures	☐ Blood Clots	☐ HIV positive	☐ Dislocations
☐ German Measles	☐ Hepatitis	☐ Glaucoma	☐ Bleeding Problems	☐ Mononucleosis	☐ Chemical/Drug Poisoning
☐ Rheumatic Fever	☐ Diabetes	☐ Anemia	☐ Food Poisoning	☐ Knocked unconscious	☐ Head Injury
☐ Broken bones	☐ Concussion				

☐ Hospitalization-reason:

☐ None

Prescriptions you are currently taking: ☐ N/A

Name of Medication	Dosage	Benefit	Prescribing Physician

Allergies: ☐ N/A

Medication/Food/Substance	What is the reaction?

Family History:

Who were you primarily raised by (family of origin):

☐ Birth parents ☐ Mother only ☐ Mother and stepfather ☐ Grandparents ☐ Foster parents
☐ Adoptive parents ☐Father only ☐ Father and stepmother ☐ Other family members

If other family members, please identify:

Current relationship with parental caretakers

Identify your biological siblings and current relationship:

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In the family of origin: Did the primary caregivers argue frequently? ☐ yes ☐ no ☐ unknown Did the arguments include verbal abuse? ☐ yes ☐ no ☐ unknown Did the arguments include physical violence? ☐ yes ☐ no ☐ unknown Did caregivers separate/divorce? ☐ yes ☐ no ☐ unknown If yes, what age were you at the time? _____ Were there severe financial troubles? ☐ yes ☐ no ☐ unknown Other information:	In the family of origin: Was anyone the victim of physical or sexual abuse (including the client)? ☐ yes ☐ no ☐ unknown Please explain:

Childhood:

What adjectives best describe you during childhood?
☐ shy ☐ distant ☐ demanding ☐ loner ☐ outgoing ☐ hyper ☐ tense ☐ loving ☐ angry ☐ clingy ☐ not known
Other: _____
_____
_____

Did you experience any of the following during your childhood? Please check any that apply and explain.
☐ illness ☐ injury ☐ trauma ☐ prolonged separations ☐ not known
Other information or comments: _____
_____
_____

Childhood Mental or Behavioral Health Diagnosis?

_____

School Experience:

Were your grades: ☐ Mostly A's ☐ A's & B's ☐ Mostly B's ☐ B's & C's ☐ Mostly C's ☐ Mostly D's & F's	
Did you have any prolonged absences from school? ☐ Yes ☐ No Please explain:	Were you ever held back for any reason? ☐ Yes ☐ No Specify grade _____ Please explain:
Did you participated in any special services? ☐ Yes ☐ No Please explain:	Identified Learning Disabilities: ☐ Yes ☐ No Please explain:
Describe involvement in any extra-curricular activities:	Were you ever suspended or expelled from any activity? ☐ Yes ☐ No Please explain:
What was your attitude towards school? ☐ Like it ☐ Dislike it ☐ Excited ☐ Indifferent ☐ Bored ☐ Motivated ☐ Afraid of going to school	How did you interact with your peers? ☐ positive ☐ well liked ☐ negative ☐ few friends ☐ did not interact with peers ☐ unknown
Other comments about school:	

Client Name: _____ Client ID: _____Date: _____

Military History: ☐ NA

Currently Active? ☐ yes ☐ no
Type of Discharge?

Deployments:

Injuries/conditions related to service:

History of Trauma:

Abuse: ☐ yes ☐ no ☐ experienced ☐ witnessed
Neglect: ☐ yes ☐ no ☐ experienced ☐ witnessed
Violence: ☐ yes ☐ no ☐ experienced ☐ witnessed
Sexual Abuse: ☐ yes ☐ no ☐ experienced ☐ witnessed
Please explain all yes answers below:

Present Situation:

Family member's names (living in household):	Age:	Relationship to you:

Describe your relationships with others in the home:

Family Annual Income:

Leisure Activities:

Identify activities that you enjoy:

Client Name: _____ Client ID: _____Date: _____

Personal Strengths:

Identify your strengths:

Cultural affiliation:

Are cultural, religious, or spiritual beliefs a significant factor in your life? ☐ yes ☐ no ☐ unknown Please explain:
Are you involved in church/religion/faith community? ☐ yes ☐ no ☐ unknown If yes, what denomination? _____ Describe support received from this community, if any:
Other comments regarding culture/spiritual/belief systems, including any preferences in regards to counseling services:

Employment: ☐ N/A

Do you work? ☐ yes ☐ no If yes, please identify type of work and hours worked per week: Are you satisfied with your current work situation? ☐ yes ☐ no Please explain: Identify past work experiences, skill or trade:

Education:

Level of education obtained:
Type of training obtained (degrees, certificates, etc.):
How do you rate your English reading/writing skills? ☐ Good ☐ Fair ☐ Poor

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Mental Health History:

Have you received mental health counseling or psychiatric treatment in the past? ☐ Yes ☐ No

If yes, please complete the chart below:

Facility/Provider:	Dates:	Diagnosis:	Reasons for treatment:

Have you ever been hospitalized for mental health or substance abuse problems? ☐ yes ☐ no

If yes, please complete the chart below:

Hospital Name:	Dates of Service:	Diagnosis:	Reason for stay:

Have you any of your family members experienced any of the following:

	Self	Mother	Father	Sister	Brother
Depression/Bipolar	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Psychiatric Hospitalization	☐	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐	☐
Suicidal Attempts	☐	☐	☐	☐	☐
Alcohol Problems	☐	☐	☐	☐	☐
Drug Problems	☐	☐	☐	☐	☐
Other Mental Health Struggles	☐	☐	☐	☐	☐

Other comments regarding mental health history:

Do you experience any of the following? (Check all that apply)

☐ anxiousness ☐ anger ☐ sadness ☐ moodiness ☐ poor attention skills ☐ inability to focus ☐ relationship problems ☐ poor boundaries
☐ difficulty getting along w/others ☐ sleep disturbances ☐ difficulty with authority ☐ grief and loss issues ☐taking unnecessary risks

Check any of the following events that have occurred in your life within the last 2 years:

☐ change of residence ☐ death of a friend ☐ loss of employment ☐ divorce ☐ poor health ☐ separation
☐ death of a family member ☐ other trauma/loss (specify below)

NOTE: If divorce or separation were checked above, please state the legal conditions of visitation and custody:

Client Name: _____ Client ID: _____Date: _____

Sexual History:

☐ N/A ☐ not currently sexually active ☐ currently sexually active, describe current sexual involvement:

☐ history of sexual assault, please explain:

☐ gender identity issues, please explain:

☐ history of sexually transmitted diseases, please explain:

☐ History of pregnancies and/or live births and/or abortions, please explain:

Drug or alcohol issues: ☐ NA

Please list substances used in the last 30 days:

History of substance abuse:

If past issues with dependency/abuse with no past 30-day use, please describe methods to remain clean and sober:

Legal History: ☐N/A

Do you have a legal or criminal record? ☐ yes ☐ no If yes, please explain:

Does your household have emergency procedures determined for any of the following situations? If so, what are they?

Tornados?

Fire?