



## ADULT INTAKE FORM

### About You Personally

Name \_\_\_\_\_ Prefer to be called \_\_\_\_\_

Gender:      Male          Female      Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_      Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Place of employment \_\_\_\_\_

Current Address \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

If you have served in the armed forces, please complete the following:

Branch \_\_\_\_\_ Years of service \_\_\_\_\_ Rank \_\_\_\_\_

Current Marital Status:      single      married      divorced      widowed

Reason for coming to counseling today \_\_\_\_\_

### About Your Family

Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Please provide the following information about your children from oldest to youngest

Name	Age	Birthdate	Relationship				Living at home?	
			biological foster	adoptive	half	step	yes	no joint
			biological foster	adoptive	half	step	yes	no joint
			biological foster	adoptive	half	step	yes	no joint
			biological foster	adoptive	half	step	yes	no joint
			biological foster	adoptive	half	step	yes	no joint

Regarding your parents, are they: Married Separated Divorced  
Is your mother: Living Deceased Is your father: Living Deceased  
How would you describe your relationship with them?

---

---

The following questions refer to your biological family:

Have you, or anyone in your family, ever been diagnosed as having schizophrenia?	Yes	No
Have you, or anyone in your family, ever been diagnosed as being depressed?	Yes	No
Have you, or anyone in your family, ever been diagnosed as having a drug or alcohol problem?	Yes	No
Have you, or anyone in your family, ever been diagnosed as being manic/depressive or bipolar?	Yes	No
Have you, or anyone in your family, ever been diagnosed as having a form of autism?	Yes	No

#### About Your Spiritual Affiliation

Please indicate with which, if any, spiritual group or church denomination you are affiliated

---

If you are affiliated with a specific church, please give the name of the church

---

Are you actively involved in the life of this group/church? Yes No

#### About Your Medical History

Name of medical doctor \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Date of last physical exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

General physical condition \_\_\_\_\_ Current physical problems \_\_\_\_\_

---

Have you ever been hospitalized? Yes No If yes, most recent date

---

Have you been prescribed a medication that you are not taking as directed? Yes No

If you are taking any medications now—prescription, herbal, or over-the-counter, please list

Medication	Dosage	Frequency	Prescribed for.....	Date began taking

Person to contact in an emergency \_\_\_\_\_

Relationship to you \_\_\_\_\_

Their phone numbers: home \_\_\_\_\_ work \_\_\_\_\_

Do you have a guardianship or conservator?      Yes      No

If yes, their name & number  
\_\_\_\_\_

Have you ever been hospitalized for a psychological problem?      Yes      No

Have you ever considered suicide?      Yes      No      Have you ever attempted suicide?      Yes      No

Self Description/Anything important not already addressed:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### About Your Desire for Counseling

By whom were you referred for counseling \_\_\_\_\_

Relationship \_\_\_\_\_



**Desired Outcome:**

---

---

---

Do you or your spouse have an order of protection or restraining order in place?    Yes    No  
If so,    You    or    Your spouse

I certify that the information contained herein is complete and accurate, to the best of my knowledge. I voluntarily consent to the counseling that I receive at Crosspoint Counseling Center.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)