crosspoint counseling

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 adoptive half step foster	yes no joint
			biological adoptive half step foster	yes no joint
			biological adoptive half step foster	yes no joint
			biological adoptive half step foster	yes no joint
			biological adoptive half step foster	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 _____

Within the last five years, have you experience any of the following?

Change in jobs? Yes No

Significant change in income? Yes No

Marriage? Yes No
(Yours, a child's or a parent's)

Divorce? Yes No

Loss from a natural disaster? Yes No
(wind, water, fire)

A move? Yes No

Birth of a child? Yes No

Death of a pet? Yes No

Adoption of a child? Yes No

Inability to conceive a child? Yes No

Significant spiritual event? Yes No

Have you sought counseling from a counselor, pastor, therapist, psychologist or psychiatrist before? Yes No

If yes, please answer the following

Age	Duration	Counselor's Name	Reason for Counseling	Outcome

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)