Elaine Barron Counseling
12700 Century Dr. Suite E
Alpharetta, GA 30009
678-807-9868

Adult Clinical Intake Form

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Name_______________________________________ Date: ____________________

Date of Birth____________________________ Initial appt. date_____________________

SS#____(if required for insurance submission)

Employer____

Employer Address:____

Telephone:(H) ____________________(W)_______________

Emergency Contact:

Name______________________ Relationship_______________ phone____________________

Marital Status______________________________

By whom were you referred?____

B. Chief concern

Please describe the main difficulty that has brought you to our office:

____

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____

On the scale below please estimate the severity of your problem(s):

Mildly upsetting____ Moderately upsetting_____ Very Severe_____ Extremely severe_____ Totally Incapacitating_____

When did your problems begin (dates and/or significant events):

____

____

C. Medical History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction	Allergy medications you take

3. List *all* non-psychiatric medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

4. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

5. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

6. Health habits

a. What kinds of physical exercise do you get?

b. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

c. Do you try to restrict your eating in any way? How? Why?

d. Do you have any problems getting enough sleep?

7. For women only

a. At what age did you start to menstruate (get your period):__________

b. Menstrual period experiences:

- How regular are they? ______________________________
- How long do they last? ______________________________
- How much pain do you have? ______________________________
- How heavy are your periods? ______________________________
- Other experiences during period? ______________________________

c. Please list all of your pregnancies:

What happened with pregnancy?

Your age	Miscarriage/Abortion/Child born	Problems?

d. Menopause:

a. If your menopause has started, at what age did it start? ______________

b. What signs or symptoms have you had?

8. Other

Are there any other medical or physical problems you are concerned about?

9. Have you ever received psychological or psychiatric or counseling services before? If yes, please indicate:

When? From whom? For what? With what results?

10. Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate:

When? From whom? For what? With what results?

11. Have your ever attempted suicide?____________________

12. Have you ever been hospitalized for a mental condition? If so, where and when?

Place Date

13. Has anyone in your family suffered from any "mental disorder"? If so, whom:

14. What sort of work are you doing now? Does your present work satisfy you?

15. What kinds of jobs have you held in the past?

16. What are your current ambitions?

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with other adults present:

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties:

4. Your relationship with your brothers and sisters, in the past and present:

E. Abuse history: ☐ I was not abused in any way. ☐ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?

Underline any of the following that were applicable to your childhood/adolescence:

Happy childhood	School problems	Medical problems
Unhappy childhood	Family problems	Alcohol abuse
Emotional/Behavior problems	Strong Religious Convictions	Legal Troubles

F. Present relationships

1. How do you get along with your present spouse or partner?

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____

____

2. How do you get along with your children?

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____

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3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

G. Chemical use

1. Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener"? ☐ No ☐ Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?______________
6. How much tobacco do you smoke or chew each week? ______________
7. Which drugs (not medications prescribed for you) have you used in the last 10 years?

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Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

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H. Spiritual

Describe your faith history and the significance of your faith in the here and now.

I. Legal history

1. Are you presently suing anyone or thinking of suing anyone? If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? If yes, please explain:

4. If you are involved in legal litigation, please provide your current attorney's name: ____________ Phone: ______

5. Are there any other legal involvements I should know about?

I. STRENGTHS:

1. What are some special talents or skills that you feel proud of?

2. What are some ways that you relax? Play? Spend free time?

Adult Checklist of Concerns

Please check all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Co-dependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

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Of the concerns marked which would you most like help with?__________________________

I VERIFY THAT THIS INFORMATION IS ACCURATE AND COMPLETE. I AGREE TO DISCUSS ANY ADDITIONAL AREAS OF CONCERN WITH THE THERAPIST

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

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Client Signature_______________________________ Date ________________________