Meredith Counseling and Consulting, LLC
Adult Intake Form

Name: _____ Date:_____
Birthdate:_____ Referral Source: _____
Address: _____
_____

Home Phone: _____ Okay to leave message? _____
Cell Phone: _____ Okay to leave message? _____ Text? _____
Work Phone: _____ Okay to leave message? _____

Name of Emergency Contact: _____ Relationship to you: _____
Emergency Contact's Home Phone: _____ Cell/Work Phone: _____

Members of the Household:

Name	**Age**	**Relationship to you**

List any children living outside the household and their ages: _____
_____

Educational/Vocational Background

Number of years of education completed _____ Please list degree(s) achieved and school (s) attended: ___
_____
_____

Are you currently employed? _____ If yes, please list position, title, name of employer, and length of time at employment: _____
_____

If you are not working, how long have you been un-employed? _____

Have you ever served in the military? _____ If yes, please list branch, rank, and current status (active/discharged): _____

Please list your personal hobbies and interests:_____
_____

Relationship, Social and Legal Information

Are you single? _____ Married? _____ If so, how many years? _____ Divorced? _____
Number of Marriages: _____ If widowed, your age at death of spouse: _____
Sexual Orientation? _____

Are you currently involved in divorce or child custody proceedings? _____ Are you currently involved in any other legal issues? _____ If yes, please explain: _____
_____

Have you ever or do you currently engage in a personal faith practice? _____ If yes, please describe: _____
_____
How important is your faith/religion to you? Check below.
Not important _____ Somewhat important _____ Very important _____.

Family History

Are your parents married? _____ If no, your age at time of divorce: _____
If divorced, did your parents remarry? _____ If yes, list parent(s) and your age at time of remarriage:__
_____
_____
Were you ever in foster care or residential care? _____ If yes, please list age and living situation:
_____

Mother's current age: _____ If deceased, her age at death: _____ Your age at time of her death:_____
Describe your relationship with your mother: ___ Close ____ Distant ____ Conflicted

Father's current age: _____ If deceased, his age at death: _____ Your age at time of his death:_____
Describe your relationship with your father: ____ Close ____ Distant ____ Conflicted

Do you have siblings? _____ If yes, please list names, ages and your relationship (close, distant, conflicted) with them: _____
_____

Medical and Mental Health Information

Describe your physical health: Excellent _____ Good _____ Poor _____

List any current medical problems below and any medications prescribed to treat the conditions:

Medical Condition	**Medications taken (include dosages)**	**Date Prescribed**

Please list any vitamins, herbal supplements or over the counter medications you are currently taking:
_____

Do you have any allergies? _____ If so, please list: _____
Adverse reactions to allergies: _____

Have you ever been in counseling? _____ Have you ever been hospitalized for a mental health concern? _____
If yes to either, please list below:

Practitioner/Treatment Facility	**Dates of treatment**	**Issue(s) being treated/Diagnosis**	**Interventions Used**	**Was it helpful? Y or N**

Has anyone in your family ever been diagnosed with a mental illness? _____ If yes, please list relationship(s) and illness: _____

Have you ever or are you currently contemplating suicide? Currently: _____ Past: _____.
Have you ever attempted suicide? _____ If yes, please list date(s), method(s), and your age at time of attempt: _____
Have you ever or are you currently contemplating harming another person? Currently: ____ Past: _____

Has anyone in your family ever attempted suicide? _____ If yes, please list relationship: _____
Has anyone in your family ever completed suicide? _____ If yes, please list relationship: _____

Please place an "X" next to any of the following if it is a concern for you.

Depression/hopelessness		Legal issues		Couple concerns	
Suicidal thoughts/attempts		Job issues/Unemployed		Marital affairs/infidelity	
Cutting or other self-harm		Financial problems		Sexuality/intimacy	
Anxiety/worry		Partner violence/abuse		Divorce adjustment	
Chronic pain or illness		Alcohol/drug concerns		Remarriage adjustment	
Sleep problems		Other addictions issues		Major life changes	
Eating problems		Poor concentration		Obsessive behaviors	
Loss/grief		Low self-esteem		Trauma experience	

Substance Use/Other Addictive Issues/Behaviors

Do you smoke? _____ If yes, indicate amount and frequency: _____
Do you chew tobacco? _____ If yes, indicate amount and frequency: _____

Do you gamble? _____ If so, have you ever lied to people important to you about how much you gambled? _
Have you ever felt the need to bet more and more money? _____

Please indicate if you have ever used the substances below:

Substance	Amount of use	Frequency of use	Time period of use
Alcohol			
Marijuana			
Cocaine/Crack/Meth			
Inhalants			
Stimulants			
Hallucinogens			
Heroin/Opiates			
Prescription Drugs (specify)			
Other (specify)			

Have you ever believed your substance use was a problem? _____ Has anyone ever told you they believed your substance use was a problem? _____ Have you felt bad or guilty about your substance use?____
Have you ever had withdrawal symptoms when trying to stop using any substances? _____
Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? _____
If yes, please describe: _____

Have you ever participated in drug and alcohol treatment? _____ If yes, please list type, length, dates, and age at time you received services: _____
_____
Do you currently or have you ever attended Alcoholics or Narcotics Anonymous? _____ If yes, please list length of time sober and number of meetings you attend per week: _____

Personal Concerns and Goals for Counseling

What are the primary issues for which you are seeking counseling/therapy?

1. _____
2. _____
3. _____

What do you hope to achieve through this experience? _____
_____

To the best of my knowledge, I attest that the information written on pages 1-4 is true and accurate.

_____ _____
Client Signature Date

_____ _____
Signature of Therapist Reviewing Form Date

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