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? _____

If you are coming in for Couples or Family counseling, or you are requesting individual counseling for relationship problems, please briefly describe the issues for which you are seeking counseling:

_____
_____
_____

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 (check one): 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 (check one): Close ☐ Distant ☐ Conflicted ☐

Do you have siblings? _____ If yes, please list names, ages and your relationship with them:
_____
_____

Medical and Mental Health Information

Describe your physical health: Excellent _____ Good _____ Poor _____
List any current medical problems and any medications prescribed to treat the conditions:

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

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

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

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

Practitioner/Treatment Facility	**Dates of treatment**	**Issue being treated/Diagnosis**

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 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