ADULT INTAKE

Client's Full Legal Name: _____ Date: _____

Preferred Name: _____ Pronouns: _____

DOB: _____ Age: _____ Gender Identity: _____

Sexual Orientation: _____ Marital Status: _____

Partner/Spouse Name: _____

Legal Custodian (if applicable): _____

Reason(s) for seeking counseling services/presenting issue(s): (Check all that apply)

- ☐ Fears/Phobias/Worries
- ☐ Sleeping Concerns
- ☐ Sexual Concerns
- ☐ Legal Concerns
- ☐ Court Appearance/Jail Term
- ☐ Child Protection Investigation
- ☐ Concerns About Childhood
- ☐ Mandated By: _____
- ☐ Family Concerns
- ☐ Pregnancy/Adoption
- ☐ Gender Identity
- ☐ Drug/Alcohol Use
- ☐ Divorce/Custody
- ☐ Financial Concerns
- ☐ Death/Illness of Close Friend/Family Member
- ☐ Other: _____
- ☐ Work Difficulties
- ☐ Depressed Mood
- ☐ Mood Swings
- ☐ Eating Concerns
- ☐ Loss/Change of Job
- ☐ Move to New Residence

When did this problem(s) begin?

What changes to you want to happen as a result of counseling?

What strengths do you possess?

Living Situation(s) During Childhood/Adolescence:

- ☐ Raised with both parents
- ☐ Parents split, raised by mother
- ☐ Raised in foster/adoptive homes
- ☐ Parents not married
- ☐ Parents split, raised by father
- ☐ Other: _____

Current Living Situation of Client:

- ☐ Living independently in my residence
- ☐ With parent(s)
- ☐ With relative/guardian
- ☐ With foster family
- ☐ Friend's home
- ☐ Homeless
- ☐ Hospital **
- ☐ Residential care **
- ☐ Temporary housing **
- ☐ Nursing home **
- ☐ Group home **
- ☐ Jail

**Identify facility: _____

Primary Household:

Total number of people living in current household: _____

Household Member Name	*Relationship to Client*	*Age*

Additional Family Members or Other Support Persons:

Family/Support Person Name	*Relationship to Client*	*Age*

Quality of Relationships Between Client & Others – How well do you get along with:

Spouse/Partner	☐ Poor	☐ Good	☐ Great	☐ N/A
Children/Step-children	☐ Poor	☐ Good	☐ Great	☐ N/A
Parents	☐ Poor	☐ Good	☐ Great	☐ N/A
Siblings	☐ Poor	☐ Good	☐ Great	☐ N/A
Employer/Co-Workers	☐ Poor	☐ Good	☐ Great	☐ N/A
Friends	☐ Poor	☐ Good	☐ Great	☐ N/A

Developmental Issues

Are you aware of any complications during your mother's pregnancy with you?

☐ Yes ☐ No ☐ Unknown

Are you aware of any developmental concerns from birth to age 5?

☐ Yes ☐ No ☐ Unknown

Are you aware of any developmental concerns from birth to ages 6-18?

☐ Yes ☐ No ☐ Unknown

Functioning

Do you currently have any concerns about your: (check all that apply)

☐ Mood ☐ Appetite ☐ Energy ☐ Falling asleep ☐ Staying asleep

For any items checked above, please indicate when you were first concerned and describe your concerns:

How many hours of uninterrupted sleep do you get per night? _____

How many hours per day do you spend on technology (not school/work related)? _____

Family History

Is there any history of mental health issues on either side of your family?

☐ Yes ☐ No ☐ Unknown

If yes, describe: _____

Is there any history of medical/physical health issues on either side of your family?

☐ Yes ☐ No ☐ Unknown

If yes, describe: _____

Chemical/Substance History

Do you have any concerns about your use of alcohol or drugs? ☐ Yes ☐ No

CAGE Assessment Tool (required):

Have you ever felt that you ought to cut down on your drinking or drug use?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes	☐ No
Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes	☐ No
Have you ever had a drink or used drugs first thing in the morning (eye opener) to steady your nerves, get rid of a hangover, or get the day started?	☐ Yes	☐ No

Do you use:

	Current	Past	Never	Additional Information
Alcohol				
Street Drugs				
Inhalants				
Prescription meds beyond prescribed usage				
Other				

Caffeine Use:
Number of cups/cans per day: _____ Time of day: _____

Tobacco/Nicotine Use:
☐ Yes ☐ No ☐ Unsure If yes, amount per day: _____

Does someone in your life (close friend or family member):

	Current	Past	Never
Use alcohol in excess			
Use street drugs			
Use inhalants			
Use prescription meds beyond prescribed usage			
Have legal issues			
Other:			

Legal History
Do you have a history of legal charges? ☐ Yes ☐ No

If yes, describe: _____

Are you currently on probation/parole? ☐ Yes ☐ No

Have you ever been on probation/parole? ☐ Yes ☐ No

Have you ever been court-ordered into chemical health or mental health treatment? ☐ Yes ☐ No

Mental Health Treatment History
Previous and/or current mental health treatment? ☐ Yes ☐ No
(may include in-home services, outpatient, day treatment, psychiatric hospitalization, psychiatric partial-hospitalization, case manager (partnership, rule 79, county), other supportive services (parent aide, PCA, guardian-ad-litem))

Agency/Provider	Dates

Trauma History

Have you ever experienced or witnessed any of the following traumatic or upsetting events?

	During Childhood (age 0-17)	During Adulthood (age 18+)
None		
Physical Abuse		
Domestic Violence/Abuse		
Neglect		
Emotional Abuse		
Sexual Abuse/Molestation		
Community Violence		
Been involved with Child or Adult Protective Services (CPS)		
As a child, were you placed outside your home?		

Safety/Risk Issues

Do you have any of the following safety/risk concerns?

- ☐ Dangerous behaviors to self
- ☐ Dangerous behaviors to others
- ☐ Destruction of property
- ☐ Risk of wandering/running away
- ☐ Need for excessive supervision
- ☐ None reported

Spirituality/Religion

Are you currently engaged in any spiritual/religious activities? ☐ Yes ☐ No ☐ Unsure

If yes, describe: _____

Medical

Patient Care Communication: Ellie Mental Health prides itself on providing the best service possible and understands the importance of communicating with all service providers to offer the best service to clients. With your permission, Ellie Mental Health will coordinate your mental health services with your primary care physician.

Primary Care Physician: _____

Name of Clinic: _____

Psychiatrist/Medication-Prescribing
Provider (if different than PCP above): _____

Name of Clinic: _____

Do you have an Advanced Directive? ☐ Yes ☐ No

Health Issues

	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or Spells					
Head Injury					
Chronic Pain					
Trouble with Hearing					
Trouble with Vision					
Poisoning or Overdose History					
Serious or Chronic Illness					
Hospitalizations					
Allergies					
Infectious/Contagious Diseases					
Surgeries					

Family medical concerns that impact you: _____

Other family concerns/stressors impacting you: (i.e. financial concerns, parents/relationship stress, etc):

Medications

Medication	Start	End	Dosage	Frequency	Prescribed By	Note

Demographics

Highest education completed: ☐ K-8th Grade ☐ High School ☐ College/beyond

Racial Orientation: ☐ Caucasian ☐ African American ☐ Hispanic
☐ Native American ☐ Asian/Pacific ☐ Bi-Multi-Racial ☐ Other

Primary language: _____

Occupation: _____

Employer: _____

Gross Household Income:
☐ $0-14,999 ☐ $15,000-19,999 ☐ $20,000-29,999
☐ $30,000-39,999 ☐ $40,000-59,999 ☐ $60,000+

Household Military History: ☐ Active ☐ Past ☐ None

If Active, who? _____

Describe impact on you:
