New Dawn Counseling Center
Adult Intake Form **CONFIDENTIAL**

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as possible. You may use a separate sheet of paper or back of last page for additional comments.

Name:______________________________________ Date of Birth________________ Age______ Sex_____

Present Address____
Number *Street*

____
City *County* *State* *Zip Code*

Phone (h): ______________________ (c): ______________________ (w) ________________________

e-mail ____

Ethnicity________________ Years of Education_____ Referred by: ______________________________

Marital Status: ☐ Single ☐ Married (# of Years ______________) ☐ Divorced ☐ Separated

Presently Living With: ☐Parents ☐Spouse ☐Roommate ☐Alone ☐Other____________________

Occupation____ ☐Part Time ☐Full Time

Employed by____

Are you in school? ☐Yes ☐No If yes: ☐Full time student ☐Part time student

School/Major:____

Religious Affiliation______________________________ Church______________________________

Are you a member? ☐Yes ☐No ☐Active ☐Inactive

Family member to notify in case of emergency: Name:____

Address:____ Phone:_________________________

FAMILY MEMBERS (Use separate sheet of paper, if necessary)

Relationship	Name	Age	Grade Last Completed in School	Occupation if Out of School
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Describe any physical or medical problems you have that require medication or physical care: ______________________________

____

Are you currently receiving medical treatment? Yes ☐ No ☐
Name of Primary Care Physician: ______________________________
When did you last consult with your primary care physician? ______________________________
Are you currently taking any prescription medications? Yes ☐ No ☐ If yes, please list by name and dosage: ______________

____

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____

List previous medications and dosage: ______________________________
Any known drug allergies? Yes☐ No☐ If yes, list: ______________________________
Previous Counseling/Therapy Yes☐ No☐ If yes, when? ______________________________
With whom? Name ______________________________Address ______________________________

____

Any psychiatric hospitalizations? Yes☐ No☐ If yes, list dates, hospital/facility, pertinent medical/psychiatric personnel, and reasons for hospitalization: ______________________________

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Describe the problem which prompted you to seek counseling at this time: ______________________________

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Is the reason for which you're seeking counseling -

Job related: ☐Yes ☐No ***If yes, provide dates, pertinent information, and circumstances. If this information isn't provided, this block will be marked 'No' on the Insurance claim:*** ______________________________

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____

Auto Accident related: ☐Yes ☐No If yes, please provide dates, pertinent information and circumstances: ______________

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____

Other Accident related: ☐Yes ☐No If yes, please provide dates, pertinent information and circumstances: ______________

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Have there been times when the problem got better? ☐Yes ☐No If yes, when and what do you think helped? ______________

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Were there times when the problems were especially bad? ☐Yes ☐ No If yes, when and what made it bad? ______________

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Are there other people who play a major role in causing your problems? ☐Yes ☐ No
If yes, who and how? ______________________________

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Is there anything else that you believe might be important for your counselor to know? ______________________________

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Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger

_____ Depression / Sadness

_____ Education

_____ Eating difficulties or overeating

_____ Fearfulness

_____ Financial Problems

_____ Nervous/anxious

_____ Marital problems

_____ Physical/Medical problems

_____ Problems with social relationships

_____ Problems with children

_____ Problems with parents

_____ Problems with other relationships (List:_________________________________)

_____Problems sleeping

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of harming others

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Use of alcohol

_____ Use of other drugs (List:______________________)

_____ Use of alcohol or other drugs by family member(s)

_____ Work

_____ Worry

_____ Other (specify) ___________________________

____
Signature

____
Date