

**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)

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Grade Last Completed in School</u>	<u>Occupation if Out of School</u>
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: _____

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: _____

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

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:** _____

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

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

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

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

Are there other people who play a major role in causing your problems? Yes No

If yes, who and how? _____

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

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 | _____ Religious/Spiritual Concern |
| _____ Depression / Sadness | _____ Sexual Concerns |
| _____ Education | _____ Thoughts of harming others |
| _____ Eating difficulties or overeating | _____ Thoughts of suicide |
| _____ Fearfulness | _____ Trouble making decisions |
| _____ Financial Problems | _____ Unhappy most of the time |
| _____ Nervous/anxious | _____ Use of alcohol |
| _____ Marital problems | _____ Use of other drugs (List: _____) |
| _____ Physical/Medical problems | _____ Use of alcohol or other drugs by family member(s) |
| _____ Problems with social relationships | _____ Work |
| _____ Problems with children | _____ Worry |
| _____ Problems with parents | _____ Other (specify) _____ |
| _____ Problems with other relationships
(List: _____) | |
| _____ Problems sleeping | |

Signature

Date