Authentic Life Counseling
1115 Elkton Drive, Suite 202
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Adult Intake Form:

Name: _____ Birthdate: _____

Address: _____

Email: _____

Insurance Provider: _____

Member ID: _____ Group Number: _____

Relationship to the Insured Subscriber: _____

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize the release of any information required to process claims.**

Signature: _____ Date: _____

Best Phone to Contact you and leave a message: _____

Is it OK to leave a message at this number? Circle YES or NO

Primary Care Name, Address, and Phone Number: _____

_____

Therapist Name, Address, and Phone Number: _____

_____

Emergency Contact: Name: _____ Number: _____

May I share information with this person(s) about your mental health condition?

Circle YES or NO

Adult Intake/ Assessment Interview

Date:

Patient Name: _____ Birthdate: _____

ALLERGIES:

Medications

Please list any medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

1. _____

2. _____

3. _____

4. _____

5. _____

PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE ROOM FOR MEDICATIONS

Primary Care Provider: _____

PCP Phone Number: _____

Do you see any specialist: Yes/ No

Specialist Name: _____

Specialty: Phone: _____

What do you consider to be the top three stresses in your life?

1. _____

2. _____

3. _____

Mood *(past 1-2* weeks): Calm Happy Sad Anxious Angry Frustrated Worried Hopeless

Helpless Other: _____

Behavioral Symptoms *(circle problems in the past month):*

Sleep Enjoying Life Motivation Fatigue Guilt Poor Concentration

Appetite Change Impulsiveness Loss of Sex Drive Racing Thoughts

Can't Stop Talking Poor Judgment Strange Thoughts or Behavior

Periods of Very High Energy Periods of Very Low Energy

Mental Health History

1. Have you been in counseling or mental health treatment before?
   (For example: Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor): *Yes / No*
2. Have you ever been hospitalized for mental or emotional problems?
   (For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc): *Yes / No*
3. Has anyone in your family had mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc): *Yes / No*
4. Have you ever been referred to Social Services? *Yes / No*

RISK ASSESSMENT (Check appropriate boxes):	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life?	_____	_____	_____	_____
2. Have you had or do you have:				
a. A specific plan how you would kill yourself?	_____	_____	_____	_____
b. Access to weapons/means of hurting self?	_____	_____	_____	_____
c. Made a serious suicide attempt?	_____	_____	_____	_____
d. Purposely done something to hurt yourself?	_____	_____	_____	_____
e. Heard voices telling you to hurt yourself?	_____	_____	_____	_____
3. Had relatives who attempted or committed suicide?	_____	_____	_____	_____
4. Had thoughts of killing or seriously hurting someone?	_____	_____	_____	_____
5. Heard voices telling you to hurt others?	_____	_____	_____	_____
6. Hurt someone or destroyed property on purpose?	_____	_____	_____	_____
7. Slapped, kicked, punched someone with intent to harm?	_____	_____	_____	_____
8. Been arrested or detained for violent behavior?	_____	_____	_____	_____
9. Been to jail for any reason?	_____	_____	_____	_____
10. Been on probation for any reason?	_____	_____	_____	_____

Physical Symptoms: Circle any that were a problem for you in the last month:

Headaches	*Dizziness*	*Heart Pounding*	*Muscle Spasms*
Muscle Tension	*Sexual Problems*	*Diarrhea*	*Vision Changes*
Numbness	*Tics/Twitches*	*Fatigue*	*Fainting* *Blackouts*
Chest Pains	*Skin Problems*	*Nausea*	*Chills/Hot Flashes*
Sweating	*Rapid Heart Beat*	*Choking Sensations*	*Stomach Aches*
Shortness of Breath	*Trembling/Shaking*	*Mouth Muscle/Joint Pain*	

If Female: Are you on any form of birth control? Yes / No
Are you, or is there a chance you might be, pregnant? Yes / No

Medical History: Check all that apply:

	Childhood	**Adult**	**Recently**
Serious Illnesses	_____	_____	_____
Serious Injuries	_____	_____	_____
Serious Head trauma	_____	_____	_____

1. Are you allergic to any medications or foods? _____If yes, please list: _____
_____

2. Do you currently have problems with pain? *Yes / No*
   If yes: Where is your pain located? _____
   How long have you had this pain problem? _____
   What things help your pain? _____
   How intense is your pain today? ***(none)*** *0 1 2 3 4 5 6 7 8 9 IO* ***(worst)***
   Do you ever take more pain medication than prescribed? Yes / No
   Are you currently being treated by another doctor for your pain? Yes / No
   If yes, who? _____

Nutrition:
Do you purge, restrict, or overeat? *Yes / No*
Have you had any difficulties or concerns related to food intake? *Yes / No*

Social History
1. Are your parents divorced? *Yes / No* If yes, how old were you? _____
2. Briefly describe your childhood *(happy, chaotic, troubled):* _____
_____
3. Are childhood events contributing to current problems? *Yes / No*
4. Current Marital Status: *Single Married Divorced Widowed Separated*
5. Number of Years Married: _____ Total Number of Marriages: _____
6. Do you have any children? *Yes / No* Ages? _____
7. Have you experienced any abuse (physical, sexual, verbal) *Yes / No*
8. How satisfied are you with your current family life? (circle one)
Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Social Support
How satisfied are you with the support you receive from your family/Friends?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
Have your current difficulties affected your family/friends/coworkers? *Yes / No*

Quality of Life: Are you satisfied with your quality of life?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
What do you do for leisure? _____
Are you able to enjoy leisure/recreational activities? *Yes / No*
If no, why? _____

Education History: Years of education completed? _____ Degree(s) _____

Job History

1. Currently employed? _____
2. How satisfied are you with your current occupation?

Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*

3. Do you have performance problems or difficulties with your boss? *Yes / No*

Alcohol Use: Do you or did you:	**In the Past**	**Recently**
1. Regularly use alcohol (more than twice per month)?	*Yes / No*	*Yes / No*
2. Had trouble (legal, work, family) because of alcohol?	*Yes / No*	*Yes / No*
3. Felt you should cut down on your drinking?	*Yes / No*	*Yes / No*
4. Been annoyed by people criticizing your drinking?	*Yes / No*	*Yes / No*
5. Felt bad or guilty about your drinking?	*Yes / No*	*Yes / No*
6. Ever had a drink first thing in the morning?	*Yes / No*	*Yes / No*

Other Substance Use/Abuse Do you or did you?	**In the Past**	**Recently**
1. Use medications (other than over the counter) that were not prescribed to you?	*Yes / No*	*Yes / No*
2. Taken more than the recommended daily dose of an over the counter medication?	*Yes / No*	*Yes / No*
3. Taken more than the prescribed dose of your prescription medication?	*Yes / No*	*Yes / No*
4. Taken or used any illegal substance?	*Yes / No*	*Yes / No*
5. Used any product or other means to get "high"?	*Yes / No*	*Yes / No*

Habits:	**In the Past**	**Recently**
1. Do you smoke or chew tobacco regularly?	*Yes / No*	*Yes / No*

2. How many caffeinated drinks do you have per day (coffee, tea, sodas)? _____

3. How often do you exercise per week? _____

Preferred Exercise: _____

4. Do you have problems with gambling?_____

5. Do you have other potentially harmful habits you want to change? _____

If so, what? _____

Goals for Treatment:

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself? _____

_____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? (Yes) (No)

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

Guardian Signature(if under 18):_____ Date: _____

Emergency Contact: _____ Date: _____