Reviving Hope Ministries

Client Intake Form

Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADULT INTAKE FORM

Name: _____

Address_____

Phone_____. Email_____

Date of Birth: _____Age:_____Gender:_____

Employer_____. Years at Current job_____

Occupation:_____ Years in field:_____

MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed

Length of current marriage/relationship:_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

How many times have you been married?_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, spouse, child, sibling)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

EDUCATION

Years of education completed: _____

Currently enrolled in High School/GED? (Y/N) _____ College? (Y/N)_____

Vocational? (Y/N) _____ Graduate School? (Y/N)_____

Other training? (Y/N) ___ If yes, what training? _____

Any Special Circumstances regarding education? _____

MILITARY

Military experience? Y/N _____ Combat experience? Y/N _____

Where:_____Branch:_____

Length of service:_____ Type of discharge:_____

Rank at discharge:_____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? _____

_____

What personal qualities would others say you have?_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did you go to counseling? _____

Do you have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _

_____

Have you used psychiatric services? Yes_____ No___

If yes, who did you see? _____

If yes, was it helpful? N/A____ Yes____ No_____

Have you taken medication for a mental health concern? Yes_____ No _____

Name of medication	Dates taken	Was it helpful? Y/N

Do you have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe. _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No

If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes, _____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes, _____No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?_____

____Inpatient _____Outpatient

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past._____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____

_____

_____

WHEN DID THESE SYMPTOMS FIRST OCCUR? _____

What would you like to see happen as a result of counseling? _____

_____

_____

What is most concerning right now? _____

_____

FAMILY HISTORY

What word would you use to describe your family of origin? _____

Are you aware of any birth trauma your mom had during her pregnancy with you, or from age 0-3?

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
DISSOCIATION						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
Eating Issues						LOW ENERGY				
DECREASED SEX DRIVE						EXCESSIVE WORRRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
IMPULSIVITY						RESTLESSNESS				
NIGHTMARES						EASILY DISTRACTED				
HOPELESSNESS						DECREASED CREATIVITY				
MOOD SWINGS						TRAUMA FLASHBACKS				
DISORGANIZED						WORK ISSUES				
SOCIAL ISOLATION						PANIC ATTACKS				
PHOBIAS						FEELING ANXIOUS				
OBSESSIVE THOUGHTS						FEELING PANICKY				
GRIEF						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
LONELINESS						OTHER				

ADDITIONAL INFORMATION

Is there anything else you would like to share:_____

_____

_____