**Tracy W. Thomas, M.Ed., LPC**

**Licensed Professional Counselor**

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**(903) 407-9701**

**Adult Intake Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (MI)

Today’s Date: \_\_/\_\_/\_\_ Your Birth Date: \_\_/\_\_/\_\_\_\_\_ Age:\_\_\_\_\_\_

Gender: € Male € Female € \_\_\_\_\_\_\_\_\_\_\_

Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number and Street) (City) (State) (Zip)

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? € Yes € No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? € Yes € No

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I email you? € Yes € No

\*Please be aware that email might not be confidential.

Person to contact in case of an emergency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Relationship to Client) (Phone)

Primary Care doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Phone)

What prompted you to seek therapy or an assessment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to my office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: € Never Married € Partnered € Married € Separated € Divorced € Widowed

Are you currently in a romantic relationship? € Yes € No

If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_

If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? \_\_\_\_\_

Do you have children? € No € Yes

If yes, how many: \_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous psychotherapy? € No € Yes

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? € Yes € No

If yes, please list names and dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, have you been previously prescribed psychiatric medication? € Yes € No

If yes, please list names and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you hopeful about your future? € Yes € No

Are you having current suicidal thoughts? € Frequently € Sometimes € Rarely € Never

If yes, have you recently done anything to hurt yourself? € Yes € No

Have you had suicidal thoughts in the past? € Frequently € Sometimes € Rarely € Never

If you checked any box other than “never”, when did you have these thoughts? \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever act of them? € Yes € No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pertinent findings: \_\_\_\_\_\_\_\_\_\_\_\_

Have you or are you being treated for any medical problems? Please check if any apply to you:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Irritable Bowel Syndrome | Cancer | Diabetes | Epilepsy | Heart Problems | Thyroid |
| Fibromyalgia | Hypertension | Bronchial Asthma | Multiple Sclerosis | Myasthenia Gravis | Stroke |
| Chronic Fatigue Syndrome | Migraine | Dementia | Addiction | Other: | Other: |

Have you ever had major surgery? € Yes € No If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies? € No € Yes If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per night you normally sleep \_\_\_\_\_

Are you having any problems with your sleep habits? € No € Yes

If yes, check where applicable:

€ Sleeping too little € Sleeping too much € Can’t fall asleep € Can’t stay asleep

Do you exercise regularly? € No € yes

If yes, how many times per week do you exercise? \_\_\_\_ For how long? \_\_\_\_\_\_

If yes, what do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any difficulty with appetite or eating habits? € No € Yes

If yes, check where applicable: € Eating less € Eating more € Bingeing € Purging

Have you experienced significant weight change in the last 2 months? € No € Yes

Do you regularly use alcohol? € No € Yes

If yes, what is your frequency? € Once a month € Once a week € Daily € Daily, 3 or more € Intoxicated daily

How often do you engage in recreational drug use? € Daily € Weekly € Monthly € Rarely € Never

If you checked any box other than “never,” which drugs to you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? € Yes € No

If yes, how many cigarettes per day? \_\_\_\_\_\_\_

Do you drink caffeinated drinks? € Yes € No

If yes, # of sodas per day \_\_\_\_\_ cups of coffee per day \_\_\_\_\_

Have you ever had a head injury? € Yes € No If yes, when and what happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last year, have you experienced any significant life changes or stressors? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Note: use rating scale with a “yes” response only.

Are you now experiencing: \*Rating Scale 1-10 (10=worst)

Depressed Mood or sadness Yes No \_\_\_

Irritability / Anger Yes No \_\_\_

Mood Swings Yes No \_\_\_

Rapid Speech Yes No \_\_\_

Racing Thoughts Yes No \_\_\_

Anxiety Yes No \_\_\_

Constant Worry Yes No \_\_\_

Panic Attacks Yes No \_\_\_

Phobias Yes No \_\_\_

Sleep Disturbances Yes No \_\_\_

Hallucinations Yes No \_\_\_

Paranoia Yes No \_\_\_

Poor Concentration Yes No \_\_\_

Alcohol/Substance Abuse Yes No \_\_\_

Frequent Body Complaints (e.g., headaches) Yes No \_\_\_

Eating Disorder Yes No \_\_\_

Body Image Problems Yes No \_\_\_

Repetitive Thoughts (e.g., Obsessions) Yes No \_\_\_

Repetitive Behaviors (e.g., Counting) Yes No \_\_\_

Poor Impulse Control (e.g., ↑ spending) Yes No \_\_\_

Self Mutilation Yes No \_\_\_

Sexual Abuse Yes No \_\_\_

Physical Abuse Yes No \_\_\_

Emotional Abuse Yes No \_\_\_

Have you experienced in the past: \*Rating Scale 1-10 (10-worst)

Depressed Mood or sadness Yes No \_\_\_

Irritability / Anger Yes No \_\_\_

Mood Swings Yes No \_\_\_

Rapid Speech Yes No \_\_\_

Racing Thoughts Yes No \_\_\_

Anxiety Yes No \_\_\_

Constant Worry Yes No \_\_\_

Panic Attacks Yes No \_\_\_

Phobias Yes No \_\_\_

Sleep Disturbances Yes No \_\_\_

Hallucinations Yes No \_\_\_

Paranoia Yes No \_\_\_

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Repetitive Behaviors (e.g., Counting) Yes No \_\_\_

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Self Mutilation Yes No \_\_\_

Sexual Abuse Yes No \_\_\_

Physical Abuse Yes No \_\_\_

Emotional Abuse Yes No \_\_\_

OCCUPATIONAL, EDUCATIONAL, LEGAL INFORMATION:

Are you employed? € No € yes

If yes, who is your current employer / position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you happy at your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list work-related stressors, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have financial concerns? € No € Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in the military? € No € Yes Previously? € No € Yes

Highest level of education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any legal concerns? € No € Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

Are you parents: € Still together € Divorced. When? \_\_\_\_\_\_\_

€ Remarried € Unmarried

€ Deceased. If yes, whom \_\_\_\_\_\_\_\_\_\_\_\_\_. Age at death \_\_\_\_\_\_\_\_\_

Number of siblings: \_\_\_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have good family support? € No € Yes From Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

|  |  |  |
| --- | --- | --- |
| Difficulty |  | Family Members |
| Depression | Yes / No |  |
| Bipolar | Yes / No |  |
| Anxiety | Yes / No |  |
| Panic Attacks | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Alcohol/Substance Abuse | Yes / No |  |
| Eating Disorders | Yes / No |  |
| Learning Disabilities | Yes / No |  |
| Trauma History | Yes / No |  |
| Suicide Attempts | Yes / No |  |
| Psychiatric Hospitalization | Yes / No |  |

OTHER INFORMATION:

What role, if any do religion and/or spirituality play in your life?

Are you satisfied with your social situation/interpersonal relationships? € No € Yes

If no, explain why:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies you use when stressed?

What are your overall goals in therapy?

What do you feel you need to work on first?

Is there anything that I did not ask about here that would be important for me to know about you?