Seeds of Hope Counseling, LLC
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Intake Form – Adult

*Please answer the following questions to the best of your ability. These questions are to help the therapist with the counseling process.

Appointment Date: _____

Name: _____
(First) (Middle Initial) (Last) (Preferred)

Client's DOB: _____ **Age:**_____ **Gender:** Male Female Other: _____

Highest Educational Level: _____

Language Spoken at Home: ( ) English ( ) Other: _____

Primary Reason for Your Visit:

_____
_____
_____
_____
_____

When Did These Problems Start?

_____
_____
_____

PLEASE CONTINUE TO THE NEXT PAGE

General Health Information

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? ( ) yes ( ) no
Reason for change:

_____
_____
_____

Are you currently taking any psychiatric prescription medication? ( ) yes ( ) no
If yes, please list:

_____
_____
_____
Prescribed by: _____

Have you been prescribed psychiatric prescription medication in the past? ( ) yes ( ) no
If yes, please list:

_____
_____
_____
Prescribed by: _____

Have you been psychiatrically hospitalized in the past? ( ) yes ( ) no
If yes, please list dates and locations:

_____
_____
_____

Please provide the name, address, and telephone number for your primary care physician (PCP):

_____
_____
_____

Date and Reason of Your Last PCP Visit:

_____
_____
_____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (i.e., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____
_____
_____

Are you currently experiencing any chronic pain? ( ) yes ( ) no
If yes, please describe:

_____
_____
_____

Are you on any medication for physical/medical issues? ( ) yes ( ) no
If yes, please list:

_____
_____
_____

How would you rate your current physical health on a scale of 1 to 10? (10 being excellent, 1 being very poor) __
How would you rate your sleeping habits on a scale of 1 to 10? (10 being excellent, 1 being very poor) __

Are you experiencing any problems with your sleep habits? ( ) yes ( ) no
If yes, circle those that apply: Sleeps too much Sleeps too little Poor Quality Disturbing dreams
Other:

_____
_____
_____

Are there any changes or difficulties with your eating habits? ( ) yes ( ) no
If yes, circle those that apply: Eating less Eating more Bingeing Restricting
Other:

_____
_____
_____

Have you experienced a change in your weight within the last two months? ( ) yes ( ) no

Do you exercise regularly? ( ) yes ( ) no
If yes, how many days per week do you exercise? _____
If yes, how many minutes/hours per session? _____

Do you consume alcohol regularly? ( ) yes ( ) no
In one month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
What kinds of recreational drugs do you use (include amount consumed/used):
( ) Caffeine ( ) Alcohol ( ) Tobacco ( ) Illicit Drugs ( ) Other: _____

_____
_____
_____

Are you currently in a romantic relationship? (Please check all that apply) ( ) yes ( ) no
( ) Married ( ) Living Together ( ) Never Married ( ) Divorced ( ) Separated ( ) Remarried

If yes, how long have you been in this relationship? _____
On a scale from 1-10 (10 being excellent, 1 being very poor), how would you rate the quality of your relationship? _____

Children: (Please list deceased and/or living)

Name: _____ Sex: ( ) M ( ) F Age: _____
Name: _____ Sex: ( ) M ( ) F Age: _____
Name: _____ Sex: ( ) M ( ) F Age: _____
Name: _____ Sex: ( ) M ( ) F Age: _____
Name: _____ Sex: ( ) M ( ) F Age: _____

With whom were you raised? (Check all that apply)

( ) Biological Parents	( ) Single Parent	( ) Institution
( ) Parents and Step-Parent	( ) Adoptive Parents	( ) Legal Guardian
( ) Foster Parents	( ) Relatives	( ) Other: _____

In the last year, have you had any major life changes? (i.e., new job, moving, illness, relationship change, etc.)

_____
_____
_____

Please circle the issues below that apply to you:

Abuse	Indecisive	Sadness
Addictions	Inferiority	Sex
Anger	Insecurity	Sleep disturbance
Anxiety	Irresponsible	Spouse/Relationship Problems
Apathy	Lonely	Stress
Carelessness	Lustful thoughts	Suicidal thoughts
Depressed mood	Memory	Tardiness
Doubts	Mood swings	Thought Process
Fear	Obsessive thoughts	Time loss
Guilt	Panic	Traumatic event
Hallucinations	Phobias	Underachievement
Headaches	Poor concentration	Withdrawn
Health	Poor decisions	Worry
Homicidal thoughts	Rebellion	
Impulsiveness	Rejection	
Inadequacy	Restlessness	

Are you currently experience any overwhelming sadness, grief, or depression? ( ) yes ( ) no
If yes, for how long?

_____
_____
_____

Have you experienced any suicidal thoughts recently? ( ) yes ( ) no
If yes, have often? Frequently Sometimes Rarely

Do you currently feel suicidal now? ( ) yes ( ) no
Comments:

_____
_____
_____

Have you ever experienced suicidal thoughts in your past? ( ) yes ( ) no
If yes, how long ago?

_____
_____
_____

How often did you have these thoughts? Frequently Sometimes Rarely

Do you currently engage in self-harm practices? (i.e., any behaviors done to intentionally harm yourself)
( ) yes ( ) no
If yes, have often? Frequently Sometimes Rarely
Additional Comments:

_____
_____
_____

Have you ever engaged in self-harm practices? ( ) yes ( ) no
If yes, how long ago?

_____
_____
_____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ( ) yes ( ) no
If yes, when did you begin experiencing this:

_____
_____
_____

Family Mental Health History

*The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected. (Include parents, brothers, sisters, grandparents, aunts, uncles, and cousins).

Depression ( ) yes ( ) no _____
Anxiety Disorders ( ) yes ( ) no _____
Bipolar Disorder ( ) yes ( ) no _____
Panic Attacks ( ) yes ( ) no _____
Alcohol/Substance Abuse ( ) yes ( ) no _____
Eating Disorder ( ) yes ( ) no _____
Trauma History ( ) yes ( ) no _____
Domestic Violence ( ) yes ( ) no _____
Sexual Abuse ( ) yes ( ) no _____
Obesity ( ) yes ( ) no _____
Obsessive Compulsive Behavior ( ) yes ( ) no _____
Schizophrenia ( ) yes ( ) no _____

*Please circle any additional problems listed below that family members may suffer from.

Suicide Attempt/Completion	Head Injury	Reading Difficulties
Suicidal Thoughts/Behaviors	Hypoglycemia	( ) Other:
Psychiatric Hospitalization	Unexplained Lapse in Time	_____
Psychiatric Medications	Child Abuse	_____
Thought Disorder	Incest	_____
Developmental Delays	Grief Issues	_____
Seizures	Cancer or Other Health Issues	_____
Sleep Disturbance	ADD or ADHD	_____
Eating Problems	Dyslexia	_____
Coordination Problems	Processing Information	
Hearing Problems	Problems	
Speech Problems	Memory Problems	

Religious/Spiritual Information

Do you practice a religion/faith? ( ) yes ( ) no
If yes, what is your faith? _____
If yes, would you like to incorporate your religion/faith into your counseling sessions? ( ) yes ( ) no
Additional Comments:
_____
_____
_____
_____

Occupational Information

Are you currently employed? ( ) yes ( ) no
If yes, who is your employer? _____
What is your position? _____
Are you happy with your current position? ( ) yes ( ) no
Does your work make you stressed? ( ) yes ( ) no
If yes, what are your work-related stressors?

_____
_____
_____

Are you currently involved in any legal proceedings? ( ) yes ( ) no
Comments:

_____
_____
_____
_____

Additional Information

List your strengths and what you like most about yourself:

_____
_____
_____
_____
_____

List areas you feel you need to develop:

_____
_____
_____
_____
_____

What are some ways you cope with life obstacles and stress?

_____
_____
_____
_____
_____

What are your main concerns/reasons for seeking treatment?

_____
_____
_____
_____

What are your goals for therapy/what would you like to accomplish?

_____
_____
_____
_____
_____

Is there anything else about yourself that has not been asked that you would like to share?

_____
_____
_____
_____
_____

*By signing below, I am acknowledging that I have chosen to receive mental health services from Jacey Wall, P-LPC, NCC at Seeds of Hope Counseling, LLC. My decision is voluntary, and I understand that I may terminate these services at any time. I also understand that during the course of treatment, I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand that I cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Client Signature **Date**