Adult Intake

New Hope Counseling

200 East Main Street
LaHarpe, Illinois, 61450

PERSONAL INFORMATION

Name _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **ZIP** _____

Occupation _____ **Highest Level of Education**_____

Phone # _____ **May we leave a message? Yes** _____ **No** _____

In Case of Emergency Contact: _____

Phone # _____ **Relationship** _____

Marital Status (circle): single married separated divorced widowed

Children and Ages _____

_____

INSURANCE *(The office will need a copy of both sides of your insurance card)*

Name of insurance provider _____ Phone #_____

Insured Name _____ DOB _____ ID #_____

Policy # _____ Group # _____

REASONS FOR SEEKING HELP

What concerns have brought you in for counseling today? _____

_____

Where are the concerns causing you the most problems? Work _____ Home _____ Marriage _____ Other _____

When did your present concerns begin to become a problem for you? _____

What concerns about you have been identified by others? _____

SPIRITUALITY

Do you believe in God? Yes _____ No _____ Do you have a religious preference?_____

Are you a member of a church? Yes _____ No _____ If yes, what church? _____

How much does your faith influence your daily life? Great _____ Moderate _____ Little _____ None _____

PRIMARY CARE PHYSICIAN

Name _____ Phone Number: _____

MEDICAL HISTORY

Serious Medical Illnesses/Accidents (Identify and give dates) _____

_____

_____

Are you on any medications? Yes _____ No _____ If yes, please list _____

_____

Any past medications. (May use back of form) _____

Surgeries or operations (Identify and give dates) _____

_____

Any hospitalizations? If so, when and for what reason. _____

_____

Have you ever been diagnosed or treated for any type of mental illness? Yes _____ No _____ If so, by whom:

Name: _____Counselor _____ Psychiatrist _____Other_____

Type of treatment or illness: _____

Please list any medications prescribed: _____

Any previous counseling or psychiatric care? Yes _____ No _____

With whom? _____ When? _____

Have you ever been treated for alcohol or drug abuse? Yes _____ No _____

If so, when and where _____

Have you been the victim of physical or sexual abuse? Yes _____ No _____

. Do you have suicidal thoughts/attempt? Yes _____ No _____ If so, when _____

SYMPTOMS

Please identify the following symptoms that relate to your situation (check all that apply):

_____ Concerns about physical health
_____ Trouble sleeping at night
_____ Trouble staying awake during the day
_____ Feeling down or unhappy/depressed mood
_____ Feelings of stress/pressure
_____ Excessive anxiety or worry
_____ Feeling inferior to others
_____ Feeling lonely
_____ Afraid of being alone
_____ Feelings of anger
_____ Difficulty making decisions
_____ Feeling "numb" or cut off from emotions
_____ Not being able to say what you really think/feel
_____ Excessive fear of specific places or objects
_____ Feeling trapped in rooms/buildings
_____ Delusions
_____ Suicidal feelings or thoughts

_____ Nightmares
_____ Concerns about emotional stability
_____ Tremors
_____ Blackouts or temporary loss of memory
_____ Loss of appetite/increased appetite
_____ Eating and then vomiting to control weight
_____ Excessive use of alcohol
_____ Abuse of non-prescription drugs
_____ Feeling distant from God
_____ Hallucinations (seeing or hearing things)
_____ Inability to concentrate while at school/work
_____ Feeling manipulated or controlled by others
_____ Lack of motivation
_____ Obsessions/compulsions with specific activities
_____ Tics
_____ Feeling sexual attracted to your own gender
_____ Loss of sexual interest or desire