

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 # _____ Email _____
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 | _____ Nightmares |
| _____ Trouble sleeping at night | _____ Concerns about emotional stability |
| _____ Trouble staying awake during the day | _____ Tremors |
| _____ Feeling down or unhappy/depressed mood | _____ Blackouts or temporary loss of memory |
| _____ Feelings of stress/pressure | _____ Loss of appetite/increased appetite |
| _____ Excessive anxiety or worry | _____ Eating and then vomiting to control weight |
| _____ Feeling inferior to others | _____ Excessive use of alcohol |
| _____ Feeling lonely | _____ Abuse of non-prescription drugs |
| _____ Afraid of being alone | _____ Feeling distant from God |
| _____ Feelings of anger | _____ Hallucinations (seeing or hearing things) |
| _____ Difficulty making decisions | _____ Inability to concentrate while at school/work |
| _____ Feeling “numb” or cut off from emotions | _____ Feeling manipulated or controlled by others |
| _____ Not being able to say what you really think/feel | _____ Lack of motivation |
| _____ Excessive fear of specific places or objects | _____ Obsessions/compulsions with specific activities |
| _____ Feeling trapped in rooms/buildings | _____ Tics |
| _____ Delusions | _____ Feeling sexual attracted to your own gender |
| _____ Suicidal feelings or thoughts | _____ Loss of sexual interest or desire |