Okapi Counseling and Family Services, PLLC

Adult Intake Information

Client's Name _____ Date_____

Gender: F ___ M ___ Date of Birth _____ Age _____

Primary reason(s) for seeking services:

__Anxiety	__Coping	__Marital problems	__Parenting
__Anger problem/issues	__Depression	__Medical/Health issues	__Relationships
__Addictive behaviors	__Eating habits	__Mental confusion	__ Sexual concerns
__Alcohol/drugs	__Family	__Job issues	__Sleeping problems

__Other concerns: _____

Relationship Status: Married____ Single____ Divorced_____
If married, how many years? _____ How many marriages? _____
If divorced, how long? _____

Religious/Cultural:
Ethnicity _____
Are there any current issues or problems due to ethnic or cultural issues? _____
If yes, please describe:_____
Religious background _____ Currently attending or not attending _____

Legal:
Are you currently involved in any criminal proceedings at the present time? Yes___ No____
If yes, please describe _____
Are you currently on probation? Yes___ No ___
If yes, please describe _____

Education:
GED ___ High school ____ Some college _____ Associates Degree ___ Bachelor's Degree ___
Masters _____ Doctorate ___ Other _____
Currently enrolled in school? Yes ___ No ___
If Yes, where: _____
Special circumstances: (learning disabilities, etc.) _____

Military:
Military Experience? Yes ____ No_____ Currently active duty? Yes___ No____
Where:_____
Branch: _____ Date of Discharge: _____

Family Information:

Relationship	Name	Age	Living	Living with you
Father			Y/N	Y/N
Mother			Y/N	Y/N

Spouse _____	Y/N	Y/N
Children _____	Y/N	Y/N
_____	Y/N	Y/N
_____	Y/N	Y/N
_____	Y/N	Y/N

Other significant extended family (siblings, grandparents, step-siblings etc.) Explain relationship

_____	Y/N	Y/N
_____	Y/N	Y/N
_____	Y/N	Y/N

Medical Health:

Please note any of the following medical or physical conditions:

__Alcoholism	__Drug Abuse	__Miscarriages
__Abortion	__Epilepsy	__Neurological disorders
__Anemia	__Fatigue	__Sexual problems
__Cancer	__Hepatitis	__Stomach problems
__Chronic Pain	__High blood pressure	__Sexual transmitted diseases
__Diabetes	__Migraines	__Thyroid problems

List any current health concerns: _____

List any recent health or physical changes: _____

Prescribed medications/Dose/Amount of time taken/Taken For/Side Effects

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Over the counter medicine (name, dose, and purpose)

_____

Prior Counseling/Treatment:

Y/N When/Where/Reason or Diagnosis given

Counseling ___ _____ _____ _____

Drug/Alcohol ___ _____ _____ _____

Treatment

Hospitalization ___ _____ _____ _____

Suicidal attempts ___ _____ _____ _____

History of Substance Use/Abuse:

Substance(s): _____

Age at first use: _____

Frequency of current use/amount: _____

Last time used: _____

Withdrawal symptoms? Y/N

Have you ever been in treatment (inpatient or outpatient) for drug and /or alcohol abuse? Y/N

Please describe (date, facility, type of treatment): _____

_____

Have drugs or alcohol ever created a problem for your relationship(s) or your job? Y/N

History of Abuse:

Have you been a victim of any type of abuse? Emotional/Physical /Sexual Abuse (please circle all that apply)

Behavioral History:

Please circle any of the following behaviors and symptoms which are causing notable distress for you:

Aggression	Phobias/Fears	Panic attacks
Alcohol dependence	Fatigue (chronic)	Pornography
Anger	Gambling	Spending problems
Anxiety	Heart palpitations	Sexual issues
Avoiding people	High blood pressure	Sleeping issues
Chest pain	Hopelessness	Speech problems
Depression	Impulsivity	Suicidal thoughts
Disorientation	Irritability	Tremors/shaking
Distractibility	Loneliness	Worrying
Dizziness	Memory issues	Social phobia
Drug dependence	Mood swings	Other: _____
Eating concerns	Hyperactivity	

How do any of the circled symptoms affect your day to day functioning? _____
_____

Does anyone in your family have a history of any mental health illnesses or concerns? Y/N
If yes, please explain: _____
_____
_____

Were there any unusual or traumatic experiences that you experienced in your childhood? Y/N
If yes, please explain briefly: _____
_____
_____

Current stressors:

Have any of the following events occurred in the last year?

Moving	Divorce	Financial problems
Marriage	Job change	Birth of a child
Natural disaster survival	Marital problems	Death of a loved one

COUNSELING GOALS:

What would you like to accomplish through counseling?

1- _____
_____

2- _____
_____

3- _____
_____