wild hope COUNSELING
6400 Canoga Ave., Suite 306 • Woodland Hills, CA 91367 • (818) 631-9608

Adult Intake Form

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. You may choose not to provide certain information. Your therapist may wish to discuss these areas with you during session.

Date_____ **Referred By**_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (____)_____ Work Phone (_____)_____

May we call you at home? Y ❑ N ❑ At Work? Y ❑ N ❑ Highest Grade Completed_____

Person to notify in case of emergency_____ Phone Number_____

Age_____ Birthdate_____ Social Security Number_____

Occupation_____ How Long?_____

- Job/Career Satisfaction (low) **1** ----------**5**---------- **10** (high)

Work Address_____ City_____ Zip Code_____

Previous Occupations_____

Insurance Provider_____ Group#_____ Insurance ID#_____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy? Y ❑ N ❑ Don't Know ❑
Church Affiliation (if any) _____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

FAMILY INFORMATION

Marital status – current: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

If married: Age of Spouse: _____ Date of Marriage:_____

If divorced: Date of marriage to ex-spouse:_____ Date of Divorce:_____

If divorced more than once: Date of previous marriage:_____Date of Previous Divorce:_____

If separated: Date of Separation: _____

If involved with a "significant other": His/her name_____ His/her occupation_____

- If you live together: since when?_____How long known?_____

Would you describe your intimate relations as satisfactory or unsatisfactory?_____

Children: Names and Ages:_____

_____

Are your children living with you?_____

Other children living with you: Names, Ages, and their Relationship to You:_____

_____

Other adults living with you:_____

_____

FAMILY HISTORY

Parents: Father: Age_____ Occupation_____

Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑

If you parents divorced, what age were you? _____Custody Arrangement: _____

- Step-father: Age_____ Step-mother: Age_____

Do you feel closest to your Father? ❑ Mother? ❑ Step Mother ❑ Step Father? ❑ None ❑ Other: _____

Briefly describe your relationship with your Father_____

With your Mother_____

Siblings: Brothers' first names & ages_____

Sisters' first names & ages_____

Other: Please explain if any member of your family has ever suffered from anything which could be described as an "emotional" or "psychological" problem:_____

_____

Please mention any history of domestic violence, child abuse or sexual abuse in your family:_____

_____

Please comment on any history of alcohol or drug abuse in your family:_____

_____

The hardest time in your development was/is: Preschool ❑ Grade School ❑ Jr. High ❑ High School ❑ College ❑ Now ❑

Additional comments: _____

_____

_____

_____

_____

_____

MEDICAL INFORMATION

MEDICAL/EMOTIONAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑

OTHER CONCERNS

Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake_____	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana_____	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)__	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other (please specify)	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

Do you exercise regularly? Y ❑ N ❑ How?_____

Have you experienced significant weight gain or loss in the past 12 months? Y ❑ N ❑

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

What recreation do you enjoy?_____

Primary Physician_____ City_____ Date of last physical_____

Additional comments: _____

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Any previous diagnoses? Y ❑ N ❑ If YES, describe: _____

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

- If YES, method used: _____

Have you ever been hospitalized for psychiatric reasons? Y ❑ N ❑

- If YES, when?_____ Length of hospital stay_____

ADDITIONAL INFORMATION

What are your strengths/talents? _____

_____

_____

_____

_____

Additional comments: _____

_____

_____

_____

_____

Following information for the individual responsible for payment:

Name _____

Occupation _____ Employer _____

Employer's Address _____ Phone _____

Annual Household Income _____ Do you own or rent? _____

How do you intend to pay for treatment? (cash or check) _____