**CENTER FOR PSYCHOLOGICAL WELLNESS, INC.**
**954-345-5644**

# ADULT CLIENT INTAKE FORM

**CLIENT NAME:** _____ **DATE OF BIRTH:** _____
**PRONOUNS:** _____ **REL'P STATUS:** _____

**SYMPTOMS**

Please place a "✓" by symptoms experienced recently.

| | | | |
|---|---|---|---|
| ☐ Anxiety/panic | ☐ Anger/outbursts | ☐ Loneliness | ☐ Loss of motivation |
| ☐ Depression | ☐ Unusual thoughts | ☐ Financial problems | ☐ Difficulty making decisions |
| ☐ Crying spells | ☐ Memory problems | ☐ Physical/medical issues | ☐ Thoughts of hurting others |
| ☐ Suicidal thoughts | ☐ Relationship problems | ☐ Impulsive behaviors | ☐ Perfectionism |
| ☐ Stress | ☐ Social withdrawal | ☐ Sexual problems | ☐ Financial problems |
| ☐ Irritability | ☐ Irrational thoughts | ☐ Eating disorder | ☐ Low energy |
| ☐ Feeling Inferior | ☐ Sleep problems | ☐ Problems at work | ☐ Religious/spiritual concerns |
| ☐ Substance Abuse | ☐_____ | ☐_____ | ☐ _____ |

Please specify if needed: _____

Please explain any stresses or life changes that you have recently experienced: _____

Please share about some of your personal strengths/important accomplishments? _____

What has motivated you to seek counseling at this time? _____

**PRIOR TREATMENT**

| YEAR | PRIMARY ISSUE(S) | THERAPIST/FACILITY | LENGTH OF TIME |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY**

Household growing up:

| NAME | RELATIONSHIP | DESCRIBE PERSONALITY/REL'P/MENTAL HEALTH ISSUES |
|---|---|---|
| | | |
| | | |

**FAMILY HISTORY (cont'd)**

| NAME | RELATIONSHIP | DESCRIBE PERSONALITY/REL'P/MENTAL HEALTH ISSUES |
|---|---|---|
| | | |
| | | |
| | | |

Experienced during childhood:

| | | | |
|---|---|---|---|
| ☐ Happiness | ☐ Neglect | ☐ Sexual abuse | ☐ Weight problems |
| ☐ Sadness | ☐ Physical abuse | ☐ Anxiety | ☐ Limited friends |
| ☐ Family fights | ☐ Didn't "fit in" | ☐ Spoiled | ☐ Parents divorced |
| ☐ Mood swings | ☐ Popular | ☐ Good grades | ☐ Learning problems |
| ☐ Attention problems | ☐ Sexual struggles | ☐ Anger | ☐ Substance abuse |
| ☐ _____ | ☐ _____ | ☐ _____ | ☐ _____ |

**HOME LIFE**

What is your current living structure? ☐ Apartment/condo ☐House ☐ Other _____

With whom do you currently live? _____

How do you spend your personal time? (hobbies, clubs, groups, etc…) _____

_____

How many times each week do you go out socially? _____

With whom do you discuss personal matters? _____

Are you satisfied with your romantic life? _____

Briefly describe the positive and negative aspects of your social and dating life. _____

_____

**EDUCATION/OCCUPATION**

Current status: ☐ Working # of hours/week _____ ☐ In school ☐ Neither

Highest level of education: ☐ GED/High School ☐ College ☐ Graduate/professional school

☐ Other _____

Educational strengths and interests: _____

College major/occupation: _____

Current job title (if working): _____

How satisfied are you with your work/school situation? _____

**RELATIONSHIP HISTORY**

Current status? ☐ Single ☐ Partnered ☐ Married ☐ Other: _____

If you are in a relationship, how long? _____ Satisfaction: _____

**RELATIONSHIP HISTORY (cont'd)**

Prior significant relationships: _____

_____

Problem areas in relationships (past and present): ☐ Trust ☐ Fidelity ☐ Substance abuse

Other: _____

**HEALTH HISTORY**

How many hours do you generally sleep each night? _____ Do you struggle with any of the following?

☐ Falling asleep ☐ Frequent awakening ☐ Wake up too early ☐ Wake up fatigued

Current Health Condition(s) ☐ None

| CONDITION | AGE AT ONSET | SYMPTOMS | MEDICATION(S) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Previous accidents and/or illness(es) ☐ None

| ACCIDENT/ILLNESS | AGE | IMPAIRMENT/TREATMENT | CURRENT STATUS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you exercise? ☐No ☐Occasionally ☐Regularly, frequency: _____

Type(s) of exercise _____

How many drinks containing alcohol do you consume in an average week? _____

Which recreational drugs have you used? _____

Do you smoke tobacco? ☐No ☐Yes, amount: _____

Have you ever taken prescription medication you were not prescribed or more than was prescribed? ☐No

☐Yes, details: _____

When was your last physical? _____

Do you have any concerns about your current physical health? ☐No ☐Yes, specify concerns: _____

_____

**PLEASE ADD ANYTHING THAT YOU DEEM PERTINENT:** _____

_____