SYNERGISM COUNSELING

Adult Intake Information

Please provide the following information and answer the questions below. Please complete this form and bring it to your first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

1. Client's Name:

_____

(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: _____Male _____Female _____Other Identity

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____Mobile Phone: ( ) _____ - _____

Mobile Phone Carrier: _____ (i.e. AT&T, Verizon) May we leave a message? ____Yes ____No

E-mail Address: _____ May we email you? ____Yes ____No

Marital Status: (circle)

Never Married Domestic Partnership Married

Separated Divorced Widowed

Emergency Contact Name: _____ Relationship to Contact: _____

Home Phone: ( ) _____ - _____Cell Phone: ( ) _____ - _____

Please list any other family members living in the same household: _____

Please list other unrelated people living in the same household: _____

2. Significant Other's Name: (if applicable)

_____

(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: _____ Male _____Female _____Other Identity

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____Mobile Phone: ( ) _____ - _____

E-mail Address: _____

May we leave messages with your significant other? _____No _____ Yes

3. Primary reason you are coming to see us?

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom or problem that is a concern. How long has it been a problem?

_____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue / Low energy
_____ Concentration problems
_____ Appetite / weight changes
_____ Withdrawal

_____ Forgetful / memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers

_____ Excessive worry / fearfulness
_____ Anxiety or panic attacks
_____ Social fears, shyness
_____ Separation problems
_____ Bedwetting / soiling
_____ Headaches, stomachaches
_____ Odd beliefs / fantasizing

_____ Lying
_____ Trouble with the law
_____ Running away
_____ Truancy / skipping school
_____ Hurting others sexually
_____ Alcohol / drug use
_____ Argumentative / defiant
_____ Swears
_____ Blames others for mistakes

_____ Morbid thoughts
_____ Suicidal thoughts or threats
_____ Suicidal plans / attempts
_____ Mood swings
_____ Depression
_____ Changed level of activity
_____ Cries easily

_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

_____ Nightmares
_____ Frequent tantrums
_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____ Odd hand / motor movement
_____ Hallucinations

_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed/annoys others
_____ Discipline problem
_____ Angry and resentful

Comments Related to Symptoms or Problems

_____

_____

_____

EDUCATION

____ High School Graduate or GED
____ Associate's Degree
____ Bachelor's Degree
____ Master's Degree
____ PHD

MEDICAL HISTORY

- Current Medical Condition(s) if any:

  _____

  _____

- Do you have a Primary Care Physician? No _____ Yes _____

- History of medical treatments, serious illness, injury, handicaps, or hospitalization?

  No _____ Yes _____ (provide information for each occurrence)

  1. Description: _____

  Date: / /

  Doctor's Name: _____ Hospital: _____

  Current Status or Outcomes? _____

  2. Description: _____

  Date: / /

  Doctor's Name: _____ Hospital: _____

  Current Status or Outcomes? _____

- Are you currently being seen by another mental healthcare provider? No _____ Yes _____

- Have you previously received any type of mental health services (psychotherapy, psychiatric, etc.)?

  _____No _____Yes (provide information for each occurrence)

Date: / / Describe: _____

Counselor or Doctor's Name: _____

Current Status or Outcomes? _____

- Are you currently taking any medications? No ____ Yes ____

  If yes, please list below:

  Medication Name: _____Dosage: _____ How Long? _____

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  Have you ever been prescribed psychiatric medication? ____Yes ____No

  If yes, please list and provide dates:

  Medication Name: _____ Dates: _____ to _____

  Medication Name: _____ Dates: _____ to _____

- List any medicines previously used for emotional or mental problems: were they helpful?

  _____

- Allergies to drugs or medicines? No ____ Yes ____ (list) _____
- Allergies to any foods? No ____ Yes ____(list) _____
- Describe allergic reactions to drugs, medicines or foods: _____

  _____

- Are there any foods that you limit or cannot eat? No ____ Yes ____(list)

  _____

- Allergies to environmental conditions? No ____ Yes ____(list)

  _____

- Does anyone in the household smoke? No ____ Yes ____
- Are you afraid someone you know may injure/harm you? No ____ Yes ____
- Do you have a Health Care Directive? No ____ Yes ____ If yes, please list where (clinic) it is on file

  _____

- Any previous testing (school/psychological)? No _____ Yes _____ Whom/where

  _____when_____

- Do you think you have any chemical dependencies? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

  Comments: _____

- Do you have a history of self-harm or suicidal attempts? No _____ Yes____

  Describe if applicable: _____

  _____

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Father, grandmother, uncle, etc.)

			Family Member
Alcohol/Substance Abuse	____No	____Yes	_____
Anxiety	____No	____Yes	_____
Depression	____No	____Yes	_____
Domestic Violence	____No	____Yes	_____
Eating Disorders	____No	____Yes	_____
Obesity	____No	____Yes	_____
Obsessive Compulsive Behavior	____No	____Yes	_____
Schizophrenia	____No	____Yes	_____
Suicide Attempts	____No	____Yes	_____
Self-Harm	____No	____Yes	_____

Comments related to Family Mental Health History:

_____

_____ ____

LIFE STRESSORS/TRAUMA HISTORY

- Have you ever been a victim of physical abuse? ____No ____Yes

  Specify: _____

- Have you ever been a victim of sexual abuse? ____No ____Yes

  Specify: _____

- Have you ever experienced significant trauma? ____No ____Yes

  Specify: _____

- Other stressors or traumas? _____

ADDITIONAL INFORMATION

1. Are you currently employed? ____No ___Yes

   If yes, what is your current employment situation?

2. Do you consider yourself to be spiritual or religious? ____No ____Yes

   If yes, describe your/your child's faith or belief: _____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish during your time in therapy?

6. Any additional comments or information that would be helpful to us?

Signature of person completing this form:

_____ _____ Date: / /

Name Relationship