Daly Counseling & Consulting, PLLC

www.dalycounseling.com

ADULT INTAKE FORM

Welcome to Daly Counseling & Consulting, PLLC.

Please complete all information requested on this form, it is important for your care.

Allow 45-60 minutes to complete.

GENERAL

Date: _____ Name:_____

How did you hear about us?_____

Phone:_____ May we leave a message? PLEASE check ONE: □ YES □ NO

Email:_____@_____

Address:_____
(street, city, zip)

Date of Birth:_____ Age:_____ Gender (PLEASE check): □ Male □ Female

Present Marital Status (check one): □ NEVER MARRIED □ ENGAGED □ MARRIED □ WIDOWED □ DIVORCED □ DIVORCED & REMARRIED □ WIDOWED & REMARRIED #OF MARRIAGES:____

Occupation:_____ Place of Employment:_____

EMERGENCY CONTACT PERSON

Name:_____ Relationship:_____

Phone:_____

PRESENTING SITUATION

Please describe what brings you to counseling?

_____
_____
_____
_____
_____

How will you know that your counseling experience has been successful?

_____
_____
_____
_____

CURRENT SYMPTOMS

Check all that apply, putting an "X" in the column of intensity, add notes if applicable.

None: Symptoms not present at this time

Mild: Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate: Significant impact on quality of life and/or day-to-day functioning

Severe: Profound impact on quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe	Notes
Depressed Mood					
Appetite Changes					
Sleeping Changes					
Feelings of Guilt					
Fatigue/low energy					
Poor Concentration					
Irritability/Anger					
Substance Use					
Anxiety					
Hopelessness					
Physical Complaints					
Social Isolation					
Worthlessness					
Loss of Pleasure or interest in hobbies					
Weight Gain					
Weight Loss					
Intense Crying					
Recurring Thoughts/images					
Feelings of Panic					
Loneliness					
Memory Impairments					
Disorganized Thoughts					

Are you presently having suicidal thoughts (now or last 3 weeks)? □ YES □ NO

If Yes, please describe:_____

Have you ever had suicidal thoughts? □ YES □ NO
If yes, when? _____

Have you ever had suicidal behaviors and/or attempted suicide? □ YES □ NO

If Yes, when & please describe:_____

FAMILY/HOUSEHOLD

Please list all people <u>living in your household</u>

Relationship *(ex. Spouse, child)*	**Name**	**Age**

FAMILY/SIGNIFICANT RELATIONSHIPS

Please list your family members and significant relationships

Relationship *(ex. mother, sister, friend)*	**Name**	**Age**	**Living?** *Check one*
			□ YES □ NO
			□ YES □ NO
			□ YES □ NO
			□ YES □ NO

			□ YES □ NO
			□ YES □ NO
			□ YES □ NO
			□ YES □ NO

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 (grandmother, aunt, uncle):

	Please check		**Family Member Relationship**
Alcohol/Substance Abuse	□ YES	□ NO	
Anxiety	□ YES	□ NO	
Depression	□ YES	□ NO	
Domestic Violence	□ YES	□ NO	
Eating Disorders	□ YES	□ NO	
Obesity	□ YES	□ NO	
Obsessive Compulsive Behavior	□ YES	□ NO	
Schizophrenia	□ YES	□ NO	
Suicide attempts	□ YES	□ NO	
Other:	□ YES	□ NO	
Other:	□ YES	□ NO	

SOCIAL RELATIONSHIPS

How do you generally get along with others, please CHECK-X- <u>all</u> that apply

□ Affectionate	□ Aggressive	□ Avoidant	□ Friendly	□ Leader
□ Outgoing	□ Follower	□ Submissive	□ Fight/argue often	□ Shy/withdrawn
□ Other:	□ Other:	□ Other:	□ Other:	□ Other:

TRAUMA HISTORY

Please complete the ACE (Adverse Childhood Experiences) Questionnaire

While you were growing up, during the first 18 years of your life:

1. Did a parent or other adult in the household **often:**

Swear at you, insult you, put you down or humiliate you?

Or

Act in a way that made you afraid you might be physically hurt?

□ YES □ NO If Yes, Enter 1:_____

2. Did a parent or other adult in the household **often**:

Push, grab, slap or throw something at you?

Or

Ever hit you so hard that you had marks or were injured?

□ YES □ NO If Yes, Enter 1:_____

3. Did an adult or person 5 years older than you **ever.**..

Touch or fondle you or have you touch their body in a sexual way?

Or

Try to or actually have oral, anal or vaginal sex with you?

□ YES □ NO If Yes, Enter 1:_____

4. Did you **often** feel that...

No one in your family loved you or thought you were important or special?

Or

Your family didn't look out for each other, feel close to each other or support each other?

□ YES □ NO If Yes, Enter 1:_____

5. Did you **often** feel that...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

□ YES □ NO If Yes, Enter 1:_____

6. Were your parents **ever** separated or divorced?

□ YES □ NO If Yes, Enter 1:_____

7. Was your mother or stepmother:

Often pushed, grabbed slapped or had something thrown at her?

Or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

Or

Ever repeatedly hit over at least a few minutes or threatened with a gun or a knife?

YES NO If Yes, Enter 1:_____

8. Did you live with anyone who was a problem drinker or alcoholic or used street drugs?

□ YES □ NO If Yes, Enter 1:_____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

□ YES □ NO If Yes, Enter 1:_____

10. Did a household member go to prison?

□ YES □ NO If Yes, Enter 1:_____

PLEASE ADD UP YOUR "YES" ANSWERS:_____

CULTURE/ETHNICITY

To what cultural or ethnic group do you belong:_____

Any cultural/ethnic information that would be helpful for your counselor to know/understand:

_____

_____

_____

SPIRITUAL/RELIGIOUS

How important are your Spiritual/Religious beliefs? Check one

□ VERY IMPORTANT □ SOMEWHAT IMPORTANT □ NOT IMPORTANT □ NOT SPIRITUAL/RELIGIOUS AT ALL

Are you affiliated with a Spiritual/Religious Group? □ **YES** □ **NO** *If Yes, what?*_____

If yes, do you regularly participate with this group? □ **YES** □ **NO** *If yes, how often?*_____

Were you raised within a spiritual or religious group? □ **YES** □ **NO** *If yes, what?*_____

Are there Spiritual/Religious issues that bother you that you would like to discuss?_____

_____

What role does faith/prayer play in your everyday life? _____

_____

How has your faith been a part or affected by this situation? _____

_____

Would you like to integrate your Spirituality into Counseling? □ **YES** □ **NO**

If yes, how?_____

LEGAL

Are you currently involved in any active cases? □ TRAFFIC □ CIVIL □ CRIMINAL □ NONE

If yes, please describe and indicate the court/hearing trial dates and charges:_____

_____

Are you currently on probation or parole? □ YES □ NO

If yes, please describe:_____

PAST: Have you had (CHECK ALL THAT APPLY) □ CRIMINAL INVOLVEMENT □ DWI, DUI, etc. □ CIVIL INVOLVEMENT

If you circled any of the above, please complete the following information:

Charges	Date	Where (city)	Results

EDUCATION

Are you currently enrolled in school or training program? □ YES □ NO

If YES, please describe:_____

Please complete the following:

Type/Name	Dates attended	Graduated	Diploma/Degree/Certificate
High School		□ YES □ NO	
College		□ YES □ NO	
Graduate		□ YES □ NO	
Post Graduate		□ YES □ NO	

Other:		□ YES □ NO	

Special educational circumstances (ex. Learning disabled, gifted):_____

_____

EMPLOYMENT

Are you presently employed? (check all that apply) □ Full-time □ Part-time □ Temporary □ Retired

□ Laid off □ Disabled □ Student □ Other:_____

Please complete for your present (if applicable) and last 3 employers:

Employer Name	**Dates**	**Title**	**Reason(s) for leaving**

MILITARY

Military Experience? □ YES □ NO Combat Experience? □ YES □ NO

Branch of military:_____

Please complete for previous military experience:

Date of Discharge:	**Type of Discharge:**
Years of Service:	**Rank at Discharge:**

MEDICAL HEALTH

Your current health is (check one): □ EXCELLENT □ GOOD □ FAIR □ POOR

List any health issues you have (I.e. diabetes, high blood pressure, etc.):_____

_____

_____

List any prescription drugs you are taking:

Drug Name	**Dosage** (mg/daily)	**Dates Taken**	**Purpose**

Primary Care Physician Name:_____ Phone:_____

Address:_____
(city, state, zip)

Date of last visit:_____ Reason(s):_____

Date of last physical:_____ Results:_____

Date of last surgery:_____Reason:_____

Upcoming surgery:_____ Date/reason:_____

Have you noticed any of the following changes? Please CHECK (X) all that apply:

□ Physical Activity Levels	□ Sleeping Patterns	□ Eating Patterns	□ Mood	□ Behavior
□ Weight	□ Energy Level	□ Enjoyment of pleasure activities	□ Other:	□ Other:

Describe any changes you checked:_____

_____

_____

Do you take/use any illegal drugs? If yes, what:_____

How Long?_____ How much?_____Frequency?_____

Do you drink alcohol? □ YES □ NO If YES, how much?_____ Frequency?_____

Describe when/where you typically use substances:_____

Describe any changes in your use patterns:_____

Describe how your use has affected your family or friends (what are their perceptions of your use?)_____

_____

Have you ever wanted to stop but feel you cannot? □ YES □ NO

COUNSELING/MENTAL HEALTH

Have you been in counseling before? □ YES □ NO

If YES, please complete:

Dates	Where/with Whom	Reason(s)

Have you ever been diagnosed with a mental health disorder? □ YES □ NO

If YES, please complete:

Date	Diagnosis

Have you ever been hospitalized for psychological reasons? □ YES □ NO

If YES, please complete:

Dates	Where	Reason(s)

Please List your **strengths:**

What are the issues you would like to work on in counseling?

Current Stresses: (CHECK-X- THAT APPLY)

□ Divorce/Separation	□ Finances	□ Illness/injury
□ Recent deaths	□ New home or job	□ Family conflict
□ Other :	□ Other:	□ Other:

What are your goals for counseling?

1._____

2. _____

3. _____

4. _____

5. _____

Are you currently seeing another counselor, a psychologist or a psychiatrist?

If YES, Name:_____ Phone:_____

Address:_____

(street, city, state, zip)

EXPECTATIONS

In a few words, what do you believe therapy is all about? _____

_____

How long do you think therapy should last? _____

How do you believe a therapist should interact with clients?_____

_____

What personal qualities do you think the ideal therapist has?_____

_____

How would you describe your desired outcomes for therapy? _____

_____

Anything else you would like your counselor to know:_____

_____

_____

_____

_____

_____ _____

Signature Date

Office Use Only

Notes:

Reviewed by:_____ _____

Printed Name & Signature Date