Smiling Spirit Pathways
122 North Salem St. Suite 201N
Apex, NC 27502
(919) 228-8859

ADULT INTAKE FORM

Please provide the following information by answering the questions below and bring this form to your first session. Please note that the information you provide here is protected as confidential information.

Client's Name: _____
(last) (first) (middle initial)

Person filling out form (if other than the client):

_____
(last) (first) (middle initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status: □Never Married □Domestic Partnership □Married
□Separated □Divorced □Widowed

Please list any children/age: _____

Address: _____
(street and number)

_____
(city) (state) (zip)

Home Phone: (_____) _____-_____ May we leave a message? □ Yes □No
Cell/Other: (_____) _____-_____ May we leave a message? □ Yes □No

Email: _____ May we email you? □ Yes □No
*Please note: Email correspondence is not considered to be a confidential means of communication.

Referred by (if anyone specific): _____

Have you previously received any type of mental health services (e.g., psychotherapy, counseling, or psychiatric services)? □No □Yes
If yes, previous therapist/practitioner: _____

If you need any more space for any of the following questions, please use the back of the paper.

Primary reason(s) for seeking services:

□Anger Management	□Anxiety	□Coping	□Depression
□Eating disorder	□Fear/Phobias	□Mental Confusion	□Sexual concerns
□Sleeping Concerns	□Addictive behaviors	□Alcohol/drugs	□Hyperactivity

□Other mental health concerns (please specify): _____

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Family History

Parents

Are the parents divorced or separated: □No □Divorced □Separated

Were the parents ever married: □Yes □No

Is there any significant information about the parents' relationship or treatment toward you which might be beneficial in counseling? □ Yes □ No

If yes, describe: _____

_____

Client's Mother

Name: _____ Age: _____ Occupation: _____ □FT □PT

Place of Employment: _____ Work Phone: _____

Mother's Education: _____

Are you currently living with your mother? □ Yes □ No

□Biological Parent □Step-parent □Adoptive Parent □Foster Parent □Other (specify): _____

If there anything notable, unusual or stressful about the relationship with the mother?

□ Yes □ No If yes, please describe: _____

_____

Client's Father

Name: _____ Age: _____ Occupation: _____ □FT □PT

Place of Employment: _____ Work Phone: _____

Father's Education: _____

Are you currently living with your father? □ Yes □ No

□Biological Parent □Step-parent □Adoptive Parent □Foster Parent □Other (specify): _____

If there anything notable, unusual or stressful about the relationship with the father?

□ Yes □ No If yes, please describe: _____

_____

Client's Siblings and Others Who Live in the Household

Name of Sibling	Age	Gender	Lives	Quality of relationship with the client
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good
_____	_____	_____	□home □away	□poor □average □good

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Others living in household	Age	Gender	Relationship to client	Quality of relationship
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good
_____	_____	_____	_____	□poor □average □good

Comments: _____
_____
_____

Family Health History

Have any of the following diseases occurred among your blood relatives? Check all that apply:

□Allergies	□Deafness	□Muscular Dystrophy
□Anemia	□Diabetes	□Obesity
□Asthma	□Glandular problems	□Perceptual motor distortion
□Bleeding tendency	□Heart disease	□Mental Retardation
□Blindness	□High blood pressure	□Seizures
□Cancer	□Kidney disease	□Spina Bifida
□Cerebral Palsy	□Migraines	□Other (specify): _____
□Cleft Lip/Palate	□Multiple sclerosis	_____

Comments regarding family health: _____
_____

Family Mental Health History

Have any of the following mental health problems affected anyone in your family? Check all that apply:

List Family Member(s)

□ Alcohol/Substance Use: _____
□ Anxiety: _____
□ Depression: _____
□ Domestic or Interpersonal Violence: _____
□ Eating Disorders: _____
□ Obsessive Compulsive Behavior: _____
□ Schizophrenia: _____
□ Suicide/Attempted Suicide: _____

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Childhood/Adolescent History

Pregnancy/Birth

Did your biological mother have any occurrences of miscarriages or stillborn births? □ Yes □ No
If Yes, please describe: _____
Describe the circumstances surrounding your mother's pregnancy/your birth: □ Planned □ Unplanned
Mother's age at birth: _____ Father's age at birth: _____ # _____ of _____ total children

While pregnant did your mother smoke? □ Yes □ No If Yes, what amount? _____
Did your mother use drugs or alcohol? □ Yes □ No If yes, type/amount: _____
Describe any physical/emotional complications for the mother or the baby during pregnancy, delivery or following the birth (e.g., diabetes, surgery, low birth weight, post-partum depression, etc.): _____
_____
_____

Infancy/Toddlerhood (Check all the apply):

□Breast fed	□Milk Allergies	□Vomiting	□Diarrhea
□Bottle fed	□Rashes	□Colic	□Constipation
□Not cuddly	□Cried often	□Rarely cried	□Overactive
□Resisted solid food	□Trouble sleeping	□Irritable when awakened	□Lethargic

Developmental History

Compared with others in the family, was your development: □ slow □ average □ fast
Age for following developments (fill in where applicable):
Began puberty: _____ Menstruation: _____
Voice change: _____ Convulsions: _____
Breast development: _____ Injuries or hospitalizations: _____
Issues that affected your development (e.g., physical/sexual abuse, inadequate nutrition, neglect):
_____

Childhood/Adolescent Peer Relationships

□Spontaneous □Follower □Leader □Difficulty making friends
□Made friends easily □Long-time friends □Shared easily
□Other (describe): _____

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Educational/Vocational History

Education

Highest grade or degree completed: _____

Are you currently attending school? □ Yes □ No

If yes, please list the name of school and program (e.g., Bachelor's Degree): _____

_____

Were you ever been held back in school? □ Yes □ No If Yes, in what grade(s): _____

What grades did/do you usually receive in school? _____

Have you ever had academic and/or disciplinary problems in school? □ Yes □ No If Yes, describe: ____

_____

Work/Vocation

Are you currently employed? □ Yes □ No

Current employer: _____ Position: _____ Hours per week: _____

Years at current job/vocational program: _____ Number of previous jobs or placements: _____

Do you enjoy your work? □ Yes □ No Is there anything stressful about your current job? _____

_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercise, diet/health, hunting, fishing, bowling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal

Please describe any current or past legal problems: _____

_____

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Medical/Physical Health

□Abortion
□Asthma
□Blackouts
□Bronchitis
□Cerebral palsy
□Chickenpox
□Congenital problems
□Croup
□Diabetes
□Diphtheria
□Dizziness
□Ear aches
□Ear infections
□Eczema
□Encephalitis
□Fevers
□Hay fever
□Heart trouble
□Hepatitis
□Hives
□Influenza
□Lead poisoning
□Measles
□Meningitis
□Miscarriage
□Multiple sclerosis
□Mumps
□Muscular dystrophy
□Nosebleeds
□Other skin rashes
□Paralysis
□Pleurisy
□Pneumonia
□Polio
□Pregnancy
□Rheumatic fever
□Scarlet fever
□Seizures
□Severe colds
□Severe head injury
□Sexually transmitted disease
□Thyroid disorder
□Vision problems
□Wearing glasses
□Whooping cough
□Other: _____
_____

List any current health concerns: _____
_____

List any recent health or physical changes: _____
_____

Are you currently experiencing chronic pain? □Yes □No If yes, since when? _____
How would you rate your current diet/nutrition habits? □Poor □Unsatisfactory □Satisfactory □Good
How would you rate your current sleeping habits? □Poor □Unsatisfactory □Satisfactory □Good

Behavioral/Emotional Health

□Affectionate
□Aggressive
□Alcohol problems
□Angry
□Anxiety
□Attachment to dolls
□Avoids others
□Bedwetting
□Blinking, jerking
□Bizarre behaviors
□Bullies, threatens
□Frustrated easily
□Gambling
□Generous
□Hallucinations
□Head banging
□Heart problems
□Hopelessness
□Hurts animals
□Imaginary friends
□Impulsive
□Irritable
□Sad
□Selfish
□Separation anxiety
□Sets fires
□Sexual addiction
□Sexual acting out
□Shares
□Sick often
□Short attention span
□Shy, timid
□Sleeping problems

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□Careless, reckless	□Lazy	□Slow-moving
□Chest pains	□Learning problems	□Soiling
□Clumsy	□Lies frequently	□Speech problems
□Confident	□Listens to reason	□Steals
□Cooperative	□Loner	□Stomachaches
□Cyber addiction	□Low self-esteem	□Suicidal threats
□Defiant	□Messy	□Suicidal attempts
□Depression	□Moody	□Talks back
□Destructive	□Nightmares	□Teeth grinding
□Difficulty speaking	□Obedient	□Thumb sucking
□Dizziness	□Often sick	□Ticks or twitching
□Drug dependence	□Oppositional	□Unsafe behaviors
□Eating disorder	□Over active	□Unusual thinking
□Enthusiastic	□Overweight	□Weight loss
□Excessive masturbation	□Panic attacks	□Withdrawn
□Expects failure	□Phobias	□Worries excessively
□Fatigue	□Poor appetite	□Other:
□Fearful	□Psychiatric problems	_____
□Frequent injuries	□Quarrels	_____

Please describe any of the above (or other) concerns? _____

_____

Are you currently in a romantic relationship? □Yes □No If yes, for how long? _____

On a scale of 1 to 10, how would you rate the health of your current relationship? _____

Medication

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Chemical Use History

Please use the chart below to describe the client's current and/or past substance use:

Name of Substance	Amount & Frequency Used	Date of 1st Use	Please specify:
_____	_____	_____	□Current □Past
_____	_____	_____	□Current □Past
_____	_____	_____	□Current □Past
_____	_____	_____	□Current □Past
_____	_____	_____	□Current □Past

Please list any current chemical use concerns: _____
_____

Counseling/Prior Treatment History

	Yes/No	When	Where	Overall experience
Counseling	_____	_____	_____	_____
Psychiatric services	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____

Are you currently experiencing suicidal thoughts or thoughts of hurting others? □ Yes □ No
If yes, please describe: _____

Have there been any significant changes or events in your life recently (e.g., loss of a loved one, new job, relocation, family stress)? □ Yes □ No If yes, describe _____
_____

Is there any additional information that you believe would assist us in better understanding you and/or your current concerns/problems? _____
_____
_____

What would you like to accomplish during therapy? _____
_____

What, if any, family involvement would you like to see in therapy? _____

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For Staff Use:

Therapist's comments: _____
_____
_____
_____
_____

Therapist's signature/credentials: _____ Date: ____/_____/_____

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