CCFS | Christian Counseling Family Services

Intake // Personal History—Adult (18+)

Client's name: _____ Date: _____

Gender: ____ F ____ M Date of birth: _____ Age: _____

Form completed by (if someone other than client):

Address: _____ City: _____ State: _____ Zip:_____

Phone (home): _____ (work): _____ ext: _____

May I leave a VM: YES or NO
(Circle)

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

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify):

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	_____	____	____	____	____
Father	_____	_____	____	____	____	____
Spouse	_____	_____	____	____	____	____
Children	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, step-relatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____

Client Name: _____ DOB:_____

Marital Status (more than one answer may apply)

____ Single ____ Divorce in process ____ Unmarried, living together
Length of time: _____

Length of time: _____

____ Legally married ____ Separated ____ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

____ Widowed ____ Annulment

Length of time: _____ Length of time: _____ Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married ____ Mother remarried: Number of times: _____

____ Parents have ever been separated ____ Father remarried: Number of times: _____

____ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe:

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

Comments re: childhood development:_____

_____

_____

_____

SOCAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify):

Sexual orientation: _____ Comments:

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe:

Any current or history of being as sexual perpetrator? ____ Yes ____ No

If Yes, describe:

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong?

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe:

Other cultural/ethnic information:

Client Name: _____ DOB:_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe:

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe:

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe:

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

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

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe:

PAST HISTORY

Traffic violations: ____ Yes ____ No DWI, DUI, etc.: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training:

Special circumstances (e.g., learning disabilities, gifted):

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Client Name: _____ DOB:_____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe):

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No

Where:

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

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

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

MEDICAL/PHYSICAL HEALTH

____ AIDS
____ Alcoholism
____ Abdominal pain
____ Abortion
____ Allergies
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bronchitis
____ Bed-wetting
____ Cancer
____ Chest pain
____ Chronic pain
____ Colds/Coughs
____ Constipation
____ Chicken pox
____ Dental problems
____ Diabetes
____ Diarrhea
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Miscarriages
____ Neurological disorders
____ Nausea
____ Nose bleeds
____ Pneumonia
____ Rheumatic fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet fever
____ Sinusitis
____ Smallpox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting
____ Whooping cough
____ Other (describe):

List any current health concerns: _____

List any recent health or physical changes:

Client Name: _____ DOB:_____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eate			
Breakfast	____ /week	_____	____ No	____ Low	____ Med	____ High
Lunch	____ /week	_____	____ No	____ Low	____ Med	____ High
Dinner	____ /week	_____	____ No	____ Low	____ Med	____ High
Snacks	____ /week	_____	____ No	____ Low	____ Med	____ High

Comments:

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

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

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe:

		Date	Reason	Results
Last physical exam	_____	_____	_____	
Last doctor's visit	_____	_____	_____	
Last dental exam	_____	_____	_____	
Most recent surgery	_____	_____	_____	
Other surgery	_____	_____	_____	
Upcoming surgery	_____	_____	_____	

Family history of medical problems:

_____

_____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above:

Client Name: _____ DOB:_____

CHEMICAL USE HISTORY

	Used in last 30 days	Method of use and amount	Frequency of use	Age of first use	Age of last use		Used in last 48 hours	
						Yes	No	Yes
		No						
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____
Heroin /Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
PCP/LSD/Mescaline	_____	_____	_____	_____	____	____	____	____
Inhalants	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over the counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs	_____	_____	_____	_____	____	____	____	____

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

SUBSTANCE ABUSE QUESTIONS

Describe when and where you typically use substances:

_____

Describe any changes in your use patterns:

_____

Describe how your use has affected your family or friends (include their perceptions of your use):

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify):

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe:

Have you had adverse reactions or overdose to drugs or alcohol? (describe):

Client Name: _____ DOB:_____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe:

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe:

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify):

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

Client Name: _____ DOB:_____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

FOR STAFF USE

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

Supervisor's comments:

_____ Physical exam: ____ Required ____ Not required

Supervisor's signature/credentials: _____ Date: ___/___/_____
(Certifies case assignment, level of care and need for exam)