# POSITIVE FRAME OF MIND COUNSELING, PLLC

# ADULT INTAKE FORM

## Note: This information is confidential.

**Demographic Information:**

**Date:** ______________________ **Name:** ______________________

**Date of Birth:** / / **Relationship Status:** ______________________

**Age:** ______________________ **Sponsor ID:** ______________________

**# of Dependents:** ______________________ **Gender: M / F** **Preferred Pronoun:** ______________________

**Home/Mobile Phone:** ______________________ **Is it ok to leave a message for you at this number? Y / N**

**Work Phone:** ______________________ **Is it ok to leave a message for you at this number? Y / N**

**Email:** ______________________ **Is it ok to email you? Y / N**

**Mailing Address:** ______________________

**City, State, Zip Code:** ______________________________

**Current Employer:** ______________________ **Position Title:** ______________________

**Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):** ______________________

**Highest Grade/Degree:** ______________________ **Type of Degree:** ______________________

**Medical Doctor's Name:** ______________________ **Medical Doctor's Phone #:** ______________________

**Psychiatrist's Name:** ______________________ **Psychiatrist's Phone #:** ______________________

**Emergency Contact Name:** ______________________ **ER Contact Relationship:** ______________________

**Emergency Contact Phone:** ______________________ **How were you referred?** ______________________

**If client is a minor for a family session please fill out the following:**

**Legal Guardian Name:**______________________________________

**Address**_______________________________________ **City**__________________ **Zip**___________

**Home phone**_______________________________ **Work phone**_______________________________

**Cell phone**_____________________________

**In regards to Texas law, a custodial parent must provide the most recent custodial agreement to protect the legal rights of the child. Please bring a copy of agreement to the first family session.**

***Children will not be seen without the document in the file. Please indicate if you are required to provide proof of custody.* Yes_______ No__________ *(please initial not check)***

**Please list all family members in your household:**

**Name:** **Date of Birth**

## Current Concerns:

**What concern brings you in?**

**Estimate the severity of this concern: Mild Moderate Severe Very Severe**

**When did this concern begin (give dates)?**

**Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:**

**Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.**

**What do you hope to accomplish in counseling?**

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

**Appetite: Any changes in appetite recently? (Please describe)**

____________________________________________________________

____________________________________________________________

____________________________________________________________

## Military History

**Are you or were you a member of the armed services? If so please list what branch:**

________________

**Were you involved in combat? Yes_________ No___________**

**If yes, were you emotionally or physically traumatized or both?**

_________________________________________

**Were you treated for this trauma and where did treatment take place?**

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

## Sleep:

**Any changes in sleep recently?**

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____________________________________________________________

____________________________________________________________

____________________________________________________________

**Usual hours of sleep _______ Current hours of sleep_________**

**Problems falling asleep or staying asleep? (Please describe)**

____________________________________________________________

____________________________________________________________

____________________________________________________________

________________________________________

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________________________________________

**Behavior – circle any of the following behaviors that apply to you:**

**Overeat Suicidal attempts Can't keep a job Take drugs Compulsions**

**Insomnia Vomiting Smoke Take too many risks Odd behavior**

**Withdrawal Lack of motivation Drink too much Nervous tics Eating problems**

**Work too hard Procrastination Sleep disturbance Crying Impulsive reactions**

**Phobic avoidance Outbursts of temper Loss of control Aggressive behavior Concentration difficulties**

**Feelings – circle any of the following feelings that apply to you:**

**Angry Guilty Unhappy Annoyed Happy Bored Sad**

**Conflicted Restless Depressed Regretful Lonely Anxious Hopeless**

**Contented Fearful Hopeful Excited Panicky Helpless Optimistic**

**Energetic Relaxed Tense Envious Jealous Apathetic Others:**

**Physical – circle any of the following symptoms that apply to you:**

**Headaches Stomach trouble Skin problems Dizziness Tics**

**Dry mouth Palpitations Fatigue Burning or itchy skin Muscle spasms**

**Twitches Chest pains Tension Back pain Rapid heart beat**

**Sexual disturbances Tremors Unable to relax Fainting spells Blackouts**

**Bowel disturbances Hear things Excessive sweating Tingling Watery eyes**

**Visual disturbances Numbness Flushes Hearing Problems Diarrhea**

**Constipation Heart Problems Nausea Vomiting High blood pressure**

**Insomnia Don't like being touched**

## Biological Factors:

**Do you have any current concerns about your physical health? Please specify:**

______________________________________________

______________________________________________

______________________________________________

**Past/present medical conditions and treatment outcome, if any:**

______________________________________________

______________________________________________

______________________________________________

**Please list all medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):**

**Medication Dose Frequency By whom (psychiatrist, endocrinologist, etc.)**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

**Please report any major illness or accidents you've had in your life:**

______________________________________________

**Please report any medical and/or psychiatric conditions of your immediate family (parents & siblings):**

**Do you have any allergies? If so please list and describe reaction to allergy:**

**Do you get regular exercise? If so, what type and how often?**

## Treatment History:

Have you been in therapy before or received any prior professional assistance for your concerns by a psychiatrist or counselor? If so, please give dates of treatments and results:

| Therapist/Hospital | Dates | Phone | Initial Reason | Outcome |
|---|---|---|---|---|
| | | | | |

## Suicide Attempt/s or Violent Behavior:

| Age | Reason | Circumstance |
|---|---|---|
| | | |

## Legal History/Pending Legal Issues

**Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes?**

**If yes, please explain:**

**Issue/Charge** **Date of occurrence**

## Check any of the following that apply to you:

| | Nev er | Rare ly | Freque ntly | Very Often |
|---|---|---|---|---|
| **Marijuana** | | | | |
| **Tranquilizers** | | | | |
| **Sedatives** | | | | |
| **Aspirin** | | | | |
| **Cocaine** | | | | |
| **Painkillers** | | | | |
| **Alcohol** | | | | |
| **Coffee** | | | | |
| **Cigarettes** | | | | |
| **Narcotics** | | | | |
| **Stimulants** | | | | |
| **Hallucinogens** | | | | |
| **Compulsive** | | | | |

| **Exercise** | | | | |
|---|---|---|---|---|
| **Use Laxatives** | | | | |
| **Early morning awakening** | | | | |
| **Fitful sleep** | | | | |
| **Binge / Purge** | | | | |
| **Poor appetite** | | | | |
| **Eat “junk foods”** | | | | |
| **Lack of interest in activities** | | | | |
| **Allergies** | | | | |

**Chemical Use:**

**Have you ever felt the need to cut down on your drinking? __ No __ Yes**
**Have you ever felt annoyed by criticism of your drinking? __ No __ Yes**
**Have you ever felt guilty about your drinking? __ No __ Yes**
**Have you ever taken a morning "eye-opener"? __ No __ Yes**
**How much beer, wine, or hard liquor do you consume each week, on average?____**
**___________________________**
**How much tobacco do you smoke or chew each day?__________________________________**
**____________________**

**Which drugs (not medications prescribed for you) have you used in the last 10 years & how frequently?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used**

**them, their effects, and so forth: _______________________________________________**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Abuse History: I was not abused in any way I was abused**

If you were abused, please indicate the following. For kind of abuse, use these letters:
P = Physical, such as beatings.
S = Sexual, such as touching/molesting, fondling, or intercourse.
N = Neglect, such as failure to feed, shelter, or protect you.

E = Emotional, such as humiliation.

**Your age Kind of abuse By whom? Effects on you? Whom did you tell? Consequences of telling?**

## Social:

**Friendships, Community & Spirituality – describe quality, frequency, activities, etc:**

**What gives you the most joy or pleasure in your life?**