POSITIVE FRAME OF MIND
COUNSELING PLLC

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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?

Usual hours of sleep _____ Current hours of sleep_____

Problems falling asleep or staying asleep? (Please describe)

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.)

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:

	Never	Rarely	Frequently	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?