auxano counseling

Adult Intake

Name: _____ Date: _____

Preferred Name: _____ Date of Birth: _____

Home Address: _____ City, State, Zip: _____

Preferred Phone:_____

Email Address: _____

May we leave messages on your preferred phone? __ Yes __ No

May we send mail to this address? __ Yes __ No

PERSONAL INFORMATION

Marital Status: __ Married __ Single __ Divorced __ Widowed __ Cohabitating

Date of Current marriage/divorce/cohabitation: _____ Number of Marriages: _____

Previously Married: Yes No If yes, when? _____ How Long: _____

Spouse/partner's Name: _____ DOB: _____

Child(ren)'s Names: _____ DOB: _____ M F

_____ DOB: _____ M F

_____ DOB: _____ M F

_____ DOB: _____ M F

CAREER/EDUCATION

Occupation: _____

Highest Level of Education: _____

MEDICAL HISTORY

How would you rate your current physical health? __ Excellent __ Good __ Fair __ Poor

Are you currently experiencing any physical problems (headaches, body aches, stomach problems) __ Yes __ No

If yes, please explain: _____

_____

Previous Hospitalizations for medical reasons: Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

Please list any learning differences: _____

MEDICATIONS (including Psychiatric) Over-the-Counter & Prescription	Dosage

COUNSELING & PSYCHIATRIC HISTORY

Have you had previous counseling? __Yes __ No If yes, when? _____

For how long? _____ Name of counselor(s) _____

For what reason? _____

Was the overall experience positive or negative? _____

What did you gain/learn in previous counseling? _____

_____

Have you ever been diagnosed with or treated for any type of mental illness? __Yes __ No If yes, which type? _____

Has a family member ever been diagnosed with any type of mental illness? __ Yes __No If yes, which type? _____

REASONS FOR SEEKING COUNSELING

What concerns have brought you to counseling today? _____

When did your present concerns become a problem for you? _____

What concerns have been identified by others? _____

Please rate the severity of your present concerns on the following scale. Check one:

__ Mild __ Moderate __ Severe __ Totally incapacitating

Please indicate which of the following areas are currently a problem for you. Check all that apply:

__ Feeling inferior to others
__ Under too much pressure & feeling stressed
__ Feeling down or unhappy/depressed mood
__ Excessive anxiety or worry
__ Feeling lonely
__ Suspicious feelings toward other people
__ Afraid of being on your own
__ Angry feelings
__ Concerns about finances
__ Cut off from emotions
__ Concerns about physical health
__ Concerns about emotional stability
__ Tremors
__ Blackouts or temporary loss of memory
__ Insomnia (not able to sleep)
__ Loss of appetite/increased appetite
__ Uncontrollable anxiety or worry
__ Lacking self confidence
__ Feeling fat
__ Eating and then vomiting to control weight
__ Excessive use of alcohol
__ Abuse of non-prescription drugs
__ Getting into trouble at school/work
__ Delusions
__ Not being able to say what you really think or feel
__ Angry outbursts
__ Excessive fear of specific places or objects
__ Difficulty making friends
__ Difficulty keeping friends
__ Feeling as if you'd be better off dead
__ Feeling manipulated or controlled by others
__ Difficulty making decisions
__ Loss of interest in sexual relationships
__ Feeling sexually attracted to members of your own sex
__ Feeling distant from God
__ Hallucinations
__ Hypersomnia (sleeping all the time)
__ Inability to concentrate while at school/work
__ Crying spells
__ Feeling 'on top of the world'
__ Nightmares
__ Loss of interest in usual activities/lack of motivation
__ Obsessions or compulsions with specific activities
__ Inability to control thoughts
__ Feeling trapped in rooms/buildings
__ Hearing voices
__ Feeling people are out to get you or that you are being watched
Other: _____

What do you hope to gain from counseling? _____

_____

How did you hear about Auxano Counseling? Who referred you to Scott? _____

FAMILY OF ORIGIN

Were you raised by your parent(s)? If not, by who? _____

Are your parents still together? Married? _____

What is the one thing that your Mom did or did not do that helped you grow? _____

What is the one thing your Mom did or did not do that held you back? _____

What is the one thing that your Dad did or did not do that helped you grow? _____

What is the one thing your Dad did or did not do that held you back? _____

SPIRITUALITY

Do you believe in God or a Higher Power? __ Yes __ No

What is your Spiritual/Religious preference? _____

Are you a part of a Spiritual/Religious community? _____

If yes, what Spiritual/Religious community? _____

How much influence does your Spirituality have on your day-to-day activity?

__ Significant __ Moderate __ Some __ None

EMERGENCY CONTACT (NEXT OF KIN- OTHER THAN SPOUSE)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City, State, Zip: _____