LAKEWOOD COUNSELING and Career Center

|| 6607 18th Avenue South, Suite #101 Richfield, MN 55423 || lakewoodcounseling.com || (P) 612-798-7373 (F) 612-243-3615 ||

ADULT INTAKE FORM

Name: ______________________________________ Age:____________ Date: _______________

Best phone # to contact you at: ___________________________

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. THIS IS FOR YOUR THERAPIST ONLY.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:

Describe what you have already done to try and deal with your concerns.

Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. ***Use space next to an issue to provide more information, if you wish.***

Do you have any of the following symptoms regularly or severely enough to cause you concern?

1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ ADD or ADHD concerns (even if undiagnosed)

____ Adoption issues

____ Alcohol or chemical abuse/dependency

____ Anger issues

____ Anorexia/bulimia/eating issues (binging, under/over-eating)

1 - In the *past*, but not now

2 - *Some* of the time (current)

3 - *Most* of the time (current)

4 - *All* of the time

____ Attempting suicide

____ Avoidance of conflict

____ Bi-polar concerns

____ Body issues

____ Childcare/parenting

____ Child development/behavior problems

____ Cigarette addiction

____ Codependency

____ Communication problems

____ Compulsive/addictive behavior

____ Concern about another's alcohol or chemical use

____ Cyber/internet sex/pornography, computer gaming or online issues (i.e. over-use, compulsivity)

____ Depression

____ Dissociation

____ Divorce/separation

____ Elder parent issues

____ Fear/sense of not being safe

____ Feeling ashamed

____ Feeling guilty

____ Feeling sad

____ Feeling suicidal

____ Financial problems/concerns

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1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

_____ Gender identity concerns

_____ Isolation

_____ Jealousy

_____ Legal problems

_____ Loneliness

_____ Loss of concentration

_____ Loss of energy

_____ Loss/grief issues

_____ Low self-esteem

_____ Marital/couple conflict

_____ Mood swings

_____ Neglect

_____ Occupational/job problems

_____ Parent/child issues

_____ Physical health issues

_____ Physically/sexually abused as an adult

_____ Physically/sexually abused as a child

_____ School-related problems

_____ Self-hate/self-loathing

_____ Self-injury

_____ Sexual identity/orientation

_____ Sexual relationship issues

1 - In the *past*, but not now
2 - *Some* of the time (current)
3 - *Most* of the time (current)
4 - *All* of the time

____ Sexuality concerns

____ Single parenting issues

____ Step-family issues

____ Verbal/emotional abuse

____ Other – *please elaborate*:

Have your symptoms impacted your daily functioning or caused you any problems at school, work or home? Please describe:

How would you describe your psychological/emotional health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent

Comments:

Please describe any current or past significant stressors in your life (school, work, relationships, financial, etc.)

Are you aware of any family history of alcoholism, addiction, depression, anxiety, bi-polar, schizophrenia, or other mental illness? ____ Yes ____ No If yes, please describe:

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Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Have others expressed concern about your alcohol or drug use? ____ Yes ____ No If yes, please describe:

Are you worried about the drug or alcohol use of a significant person in your life - i.e. spouse, parent, child, sibling? ____ Yes ____ No If yes, please describe your concern:

How do you identify your sexual orientation? ____

Are you: ____ Single ____ Married ____Divorced ____ Widowed ____ In a significant relationship

Comments:

Describe any comments or concerns regarding your living situation:

____
____
____

Legal History:
Have you had any current or past problems with the legal system? Please describe:

Are you currently involved in any legal action/litigation? Please describe:

Do the reasons you are seeking services at Lakewood have to do with legal issues? Please describe:

Work/Education:

Occupation/Title: ________________________________ Employer:___________________________
Comments:

How satisfied are you with your occupation and why?: ____
____
____

High School Attended: ________________________________ Year of Graduation: ___________

College/University: __________________________________ Year of Graduation: ___________

College/University: __________________________________ Year of Graduation: ___________

Degree(s) Earned and Major(s): ____
Interests/activities: Please describe interests or hobbies and how you spend time during a typical day.

Described your attributes that you consider to be strengths:

Described your attributes that you consider to be a source of weakness, frustration or concern (for you or others):

How would you describe your ***physical*** health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent ____ Not sure

Medical Information:

Name of Primary Physician: ______________________________ Phone:# ______________________

Name of Clinic: ____

Date and Reason of Last Physical Exam ____

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Current Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Do you take your medications regularly? If not, please explain, e.g., how often you miss doses:

Previous Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Previous Therapist(s)

Name/Clinic	Date(s)	Comment(s)

What HAS worked for you in therapy? Describe:

What has NOT worked for you in therapy? Describe:

Over →

Previous Hospitalizations, Partial Hospitalizations, Day Treatments, CD Treatments, etc

Name/Clinic/Facility	Date(s)	Comment(s)

Have you experienced any significant illnesses, accidents or surgeries? Please describe:

Describe the physical fitness program you follow, if any:

Spiritual/Religious Belief System:

Do you actively participate in a spiritual/faith community? ____ Yes ____ No

If yes, please identify/describe that community:

How important is your faith to you?

What kind of a support system do you have?

Is there anything more that you want to share?

THANK YOU

Signature ______________________________________ Date ______________________