Purposeful Counseling, PLLC
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Vancouver, WA 98661

ADULT COUNSELING INTAKE FORM

CLIENT INFORMATION

Client Name(s): _____Date: _____

Gender: Male Female Age: _____ Date of Birth: _____

Ethnic Background: _____

Spiritual Practice/ Religious Affiliation: _____

Do you have an interest in spiritual growth: Yes No

Currently attending church/ temple/ mass/ etc.: Yes No

Educational Background: _____

Occupation: _____

Referral Source: _____

CLINICAL INFORMATION

Reason for Coming to Counseling. _____

Major Sources of Stress: _____

Prescription medications, vitamins, sleep aids, other supplements currently taking

NAME OF MEDICATION	DOSE	FREQUENCY	REASON FOR USE	BENEFICIAL?

POSSIBLE CONCERNS FOR DISCUSSION IN COUNSELING:

Abuse (physical, sexual, emotional) _____Past or present (circle one)

Alcohol use	Finances	Self-control
Anger	Friends	Self-esteem
Appetite	Gambling	Shyness
Career	Health problems	Sleeplessness
Children	Inferiority feelings	Stress
Concentration	Legal matters	Suicidal thoughts
Depression	Loneliness	Thoughts
Dreams	Making decisions	Tiredness
Drug use	Marriage	Unhappiness
Education	Memory	Work
Energy	Nervousness	Other
Fears	Relaxation	

RELATIONSHIP CONCERNS

Affection	Hostility	Showing appreciation
Agreeing on chores	Housing	Solving problems together
Closeness	Infidelity	Spouses/ partner cleanliness
Common goals	In-laws	Trusting each other
Common interests	Jealousy	Use of time
Communication	Parenting	Verbal fighting
Feeling Misunderstood	Physical fighting	Other:_____
Finances	Recreation	_____
Friendships	Relatives	_____
Having fun together	Sexual Issues	_____

Please note any other individual or relationship concerns you might have:

_____

_____

_____

Ways of Coping:

_____

_____

_____

What do you consider to be your most significant strengths:

_____

_____

Previous Counseling:

Type of treatment (inpatient/ outpatient)	Provider	Approximate date range of treatment	Reason for treatment	Beneficial?

Habits/ Substance Use (Please add any illicit drugs or abuse of prescription medications as is applicable)

Substance	**Amount**	**Frequency**	**Last use**
Caffeine			
Alcohol			
Cigarettes/Nicotine			

Have you ever abused drugs or alcohol? Yes No

Substance Use Treatment:

Type of treatment (outpatient/ residential/ detox)	Provider/ Facility	Approximate date range of treatment	Reason for treatment (specify drug or alcohol abused)	Beneficial?

MEDICAL HISTORY

Are you presently under a physician's care? Yes No

Name and phone number of physician: _____

_____

If yes, What for?

_____

_____

_____

_____

FAMILY INFORMATION

Marital Status: Married Divorced Separated Single Widowed
Length of current relationship: _____
Spouse/ Partner's Name: _____ Date of Birth: _____
Previous Marriages/ Significant partners and length of relationships:

_____
_____
_____
_____
_____

Children (Include all biological, adopted, foster, and step):

Name	Sex	Age	Type (B,A,F, S)	Custody Y/N	Lives with
_____	____	____	_____	_____	_____
_____	____	____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

FAMILY HISTORY

Father's name: _____
Please use 5 words to describe your father:

_____
_____

Mother's name: _____
Please use 5 words to describe your mother:

_____
_____

Step-parent's names (and brief description of each):

_____
_____

Do you have any brothers and sisters (including adopted, foster, step))?

Name	Sex	Age	Type (B,A,F, S)	Lived with you? Y/N	Describe relationship

How would you describe your childhood?

Any family history of mental illness, Serious Medical Illness, or Substance abuse issues:

TREATMENT GOALS

If counseling were successful, what would be noticeably different?

Do you have any questions for me?

Are there any hesitations, fears, or concerns about counseling?

Please list your main counseling goals:

1.
2.
3.
4.
5.