Impact Counseling & Guidance Center
Adult Intake Form

Date: _____

ABOUT YOU

Name: _____ **DOB:** _____ **Age:** _____ **Gender:** M / F **Race/Ethnicity:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Contact Information:

Home# _____ May we leave a message? Yes | No
Work# _____ May we leave a message? Yes | No
Cell # _____ May we leave a message? Yes | No
May we leave text reminders? Yes | No
Email: _____ May we email reminders? Yes | No

Your Occupation: _____
Current Employer: _____
How Long: _____

Current Marital Status: Single | Married | Divorced | Widow | Committed Relationship

If Widowed, how long? _____
If in Committed Relationship, how long? _____

ABOUT MARRIAGE

Spouse's Name:_____ **DOB:** _____ **Age:** _____ **Gender:** M / F **Race/Ethnicity:** _____
Their Occupation: _____
Current Employer: _____
How Long: _____

How long have you been married? _____

Your ages when married? Husband: _____ Wife: _____

How long did you know your spouse before your relationship? _____

Length of dating? _____ **Length of Engagement?** _____

Please rate your happiness in your marriage on a scale of -10 (unhappy) to +10 (perfectly happy)

-10, -9, -8, -7, -6, -5, -4, -3, -2, -1, 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Have you ever been separated? Yes | No When? _____ How long? _____

Has either of you ever filed for divorce? Yes | No If yes, when? _____ Was it granted? _____

***Previous* marriages: How many? _____ and how long did they last? _____**

For any ending in death, how long did they last? _____
For any ending in divorce, how long did they last? _____
Briefly describe the reasons for *divorce:* _____

ABOUT CHILDREN

**Check first column if child is by a Previous Relationship.*

PM*	Child's Name	Gender	Age	Does Child Live With You?	Relationship of this child to you?
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other
		M | F		Yes | No	Biological Step-Child Adopted Foster Guardianship Other

ABOUT YOUR PARENTS AND FAMILY HISTORY

Were you raised by anyone other than your biological parents? Yes | No

If yes, describe who raised you? _____
If yes, did you know or have a relationship with your biological parents? _____

Was the race/ethnicity of those that raised you different than yourself? Yes | No

If yes, please identify differences _____

What best described your household while growing up:

One Mother & One Father | Single Parent | Blended Family | Other _____

Did you ever live in foster care? Yes | No If so, for how long and what ages? _____

How many sisters did you have? _____ How many brothers did you have? _____ What was your birth order? _____

While growing up did your parents divorce? Yes | No

Did your mother remarry? Yes | No Did your father remarry? Yes | No

Who did you live with? _____

Did you ever witness or experience any of the following forms of abuse growing up:

physical | sexual | mental | emotional | verbal | religious | ritual

If yes, please briefly describe _____

Have you ever been involved with an abortion? Yes | No If yes, how many? _____

Has your spouse? Yes | No If yes, how many? _____

Have you ever had an extramarital affair? Yes | No If yes, how many? _____

Has your spouse? Yes | No If yes, how many? _____

ABOUT YOUR HEALTH

Please rate your health: Very Good | Good | Average | Declining | Special Needs (Please explain) _____

Are you currently being treated for any medical conditions? _____

List any medications, dosages and for what reason you take them:

_____

_____

_____

Please rate your Sleep Pattern:

Get a good night's rest | Can't get to sleep | Wake-up, can't go back to sleep | Other, explain _____

Have you ever had psychotherapy or counseling before? Yes | No If so, please list the following information:

Provider: _____ When: _____ Reason: _____ Diagnosis: _____

Provider: _____ When: _____ Reason: _____ Diagnosis: _____

Have you ever been hospitalized for psychological or emotional illness? Yes | No If so, please list the following information:

Facility: _____ When: _____ Reason: _____ Diagnosis: _____

Facility: _____ When: _____ Reason: _____ Diagnosis: _____

Have you ever attempted suicide? _____

Are you currently having suicidal thoughts? _____

Have you ever-heard voices or seen things that were not there? Yes | No Explain: _____

Please identify any conditions or issues you experience currently, in the past, or both:

Depression:	Past	Present	Past & Present	Never
Stress:	Past	Present	Past & Present	Never
High Blood Pressure:	Past	Present	Past & Present	Never
Anxiety / Panic:	Past	Present	Past & Present	Never
Bipolar:	Past	Present	Past & Present	Never
Mood Swings:	Past	Present	Past & Present	Never
Anger:	Past	Present	Past & Present	Never
Fear:	Past	Present	Past & Present	Never
Suicidal Behaviors:	Past	Present	Past & Present	Never
Alcohol:	Past	Present	Past & Present	Never
Drugs:	Past	Present	Past & Present	Never
Sexual Issues:	Past	Present	Past & Present	Never
Physical Abuse:	Past	Present	Past & Present	Never
Sexual Abuse:	Past	Present	Past & Present	Never
Mental Abuse:	Past	Present	Past & Present	Never
Emotional Abuse:	Past	Present	Past & Present	Never
Verbal Abuse:	Past	Present	Past & Present	Never
Religious Abuse:	Past	Present	Past & Present	Never
Ritual Abuse:	Past	Present	Past & Present	Never
Cutting:	Past	Present	Past & Present	Never
Anorexia / Bulimia:	Past	Present	Past & Present	Never
Attention Deficit:	Past	Present	Past & Present	Never
Hyper Activity:	Past	Present	Past & Present	Never
Difficulty Concentrating:	Past	Present	Past & Present	Never
Compulsivity:	Past	Present	Past & Present	Never
Nightmares:	Past	Present	Past & Present	Never
Flashbacks:	Past	Present	Past & Present	Never
Headaches:	Past	Present	Past & Present	Never
Chronic Fatigue:	Past	Present	Past & Present	Never
Sleep Disorder:	Past	Present	Past & Present	Never
Diabetes:	Past	Present	Past & Present	Never
Asthma / Allergy:	Past	Present	Past & Present	Never
Apathy / Indifference:	Past	Present	Past & Present	Never
Grief/Loss/Sadness:	Past	Present	Past & Present	Never
Guilt/Shame:	Past	Present	Past & Present	Never
Hopelessness/Despair:	Past	Present	Past & Present	Never
Overeating:	Past	Present	Past & Present	Never
Obsessive Thoughts:	Past	Present	Past & Present	Never
Disgust:	Past	Present	Past & Present	Never
Loneliness:	Past	Present	Past & Present	Never
Betrayal:	Past	Present	Past & Present	Never
Abandonment:	Past	Present	Past & Present	Never
Low Self-Esteem:	Past	Present	Past & Present	Never

Please identify any parents or siblings currently experiencing, or have been treated for any of the conditions/issues listed above: _____

_____

_____

Are you Pregnant? Yes | No | Not Applicable Due When? _____

Using caffeine? Yes | No | Not Applicable Describe: _____

Smoking Cigarettes? Yes | No | Not Applicable How many daily? _____

Using recreational drugs? Yes | No | Not Applicable What? How much and often? _____

Drinking Alcohol? Yes | No | Not Applicable What? How much and often? _____

ABOUT YOUR SPIRITUAL BELIEF SYSTEM

Briefly describe your spiritual belief system? _____

If you attend worship, where do you go? _____ Regularly or Occasionally?

REFERRAL INFORMATION

Who referred you? Client | Family | Friend | Impact | LABC | Other Church | Internet Search | Phonebook
Conference or Seminar | Therapist or Other Counseling Center | Doctor or Hospital | Teacher or School

ABOUT US

Fees- We do not accept insurance and fees are due at the time services are rendered.

Special Billing-

If you have a third party offering to pay for your counseling such as a church, company, or extended family member, please complete the following information (pre-authorization is required)

Billable Church, Company or 3rd Party_____
Contact Person: _____
Billing Address: _____City _____ State _____ Zip _____
Phone: _____ Email: _____

How many sessions are they willing to pay for? _____

YOU ARE JUST ABOUT FINISHED!

Please describe your reason for seeking counseling today _____

_____

_____

_____

_____

_____

With whom else have you discussed this issue? _____

What steps have you already taken to resolve the issue? _____

What do you hope to accomplish by counseling (your expectations)? _____

What do *you* expect to do in counseling? _____

Does your spouse or family know you are seeking counseling? Yes | No

If yes, describe their supportiveness: (0 - no support, 10 - total support)

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

Is there any information we should know that we didn't think to ask already? _____

_____

_____

_____

_____

_____