Adult Client Intake Form

Military Integrative Therapies
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(757) 995-2196

Kelly Andrews MS, LPC
Licensed Professional Counselor, Art and Play Therapist

Please fill out the information below as thoroughly as possible. The information you provide here as well as in your therapeutic sessions will help provide me with a road map to help you. Please note it is protected as confidential information.

Date of Intake:_____

Name: _____

Birth date: _____/_____/_____ Age: _____

Address: _____
(Street)

_____ _____
(City) (Zip Code)

_____
(Phone) Is it safe to leave a message? Yes ☐ No ☐

E-mail: _____ May I email you? Yes ☐ No ☐
*Please note that email correspondence is not considered a confidential form of communication, however if you would like I can email an appointment reminder.

Please check the box that you identify with:

☐Heterosexual ☐Lesbian ☐Gay ☐Bi-Sexual ☐Transgender ☐Transexual

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Cohabitating

Name of spouse/partner _____

Length of relationship _____

Name of emergency contact/relation to self and phone number

_____ _____

Name **Phone number**

_____

Relation to self

Please list the family members that are currently living in your home.

_____

_____

_____

Do you have any children living outside the home? If so, please list the names and ages below.

_____

_____

_____

How were you referred to MITs? _____

General Health and Mental Health Information

How would you rate your current physical condition?
☐Poor ☐Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good
Please list any specific health problems you are currently experiencing.

_____

_____

Have you previously received any mental health services? If yes, please briefly explain below.

_____

_____

_____

Have you ever been prescribed psychiatric medication? If yes, please list medication, dose and dates:

_____

_____

Have you ever been hospitalized for psychiatric treatment including substance abuse treatment? ☐ Y ☐ N
Please circle the number of hospitalizations and briefly explain.
0 1 2 3 4 5 6 7 8 9 10+

_____

_____

_____

_____

Have you ever made statements of wanting to hurt yourself? ☐ Y ☐ N
Have you ever made statements of wanting to hurt someone else? ☐ Y ☐ N

Have you ever purposefully hurt yourself? ☐ Y ☐ N
Have you ever purposefully hurt someone else? ☐ Y ☐

If yes, Please explain in the space provided.

_____

_____

_____

_____

Please check any of the following that apply to you:

☐Headache	☐Inferiority Feelings	☐Shy with people
☐Dizziness	☐Feel Tense	☐Home conditions bad
☐Fainting Spells	☐Feel Panicky	☐Unable to have a good time
☐No Appetite	☐Fears and Phobias	☐Always Worried
☐Over-Eating	☐Depressed	☐Always Stressed
☐Stomach Troubles	☐Suicidal Ideas	☐Don't Like Weekends
☐Bowel Disturbances	☐Alcoholism	☐ Don't Like Vacations
☐Always Tired	☐Illegal Drug Use	☐Can't Make Decisions
☐Unable to Relax	☐Allergies	☐Over Ambitious
☐Insomnia	☐Asthma	☐Gambling
☐Recurrent Dreams	☐Sexual Problems	☐Job Problems
☐Nightmares	☐Afraid of Men	☐Other_____
☐Visual Hallucinations	☐Afraid of Women	_____
☐Audible Hallucinations	☐Cannot make friends	_____

Family Mental Health History

In the section below, please check to identify a family history of any of the following:
☐Depression ☐Anxiety ☐Posttraumatic Stress Disorder
☐Obsessive Compulsive Disorder ☐ Bi-Polar Disorder ☐ Schizophrenia
☐Dissociative Identity Disorder ☐Personality Disorder
☐Developmental Disorder ☐Suicide Attempt and/or Completion
☐Alcohol/Substance Abuse ☐ Eating Disorder ☐ Domestic Violence
☐ Sexual Violence ☐ Emotional Abuse ☐ Other not listed

Please explain the above marks that you checked in the space below:

_____

_____

_____

_____

_____

Do you drink Alcohol?
☐Never ☐1-3 Drinks a week ☐4-8 Drinks a week ☐9 or more drinks a week

Do you use illegal drugs?
☐Never ☐Occasionally ☐Daily

Additional Information

Are you currently employed? ☐ Yes ☐No

If yes, what is your current employment situation? Do you enjoy your job? Does it bring on stress or other discomfort?

_____

_____

_____

Have you ever served in the military? ☐ Yes ☐No
If yes; From_____ To_____
Did you ever serve in combat? ☐ Yes ☐ No (If yes, briefly explain)

_____

_____

_____

Do you consider yourself Spiritual or Religious? ☐ Yes ☐No

If yes, please describe your belief or faith in the space provided.

_____

_____

_____

Please finish the following sentences:

I consider my strengths to be…_____

_____

_____

_____

I consider my weakness to be…_____

_____

_____

_____

I consider my strengths to be…_____

_____

_____

_____

At the end of therapy I…_____

_____

_____

_____

The above information is correct, to the best of my knowledge. I understand that this information will be used by my counselor in the sessions I will be receiving at MITs. The above information will remain confidential.

_____ _____

Client Signature **Date**

_____ _____

Kelly Andrews MS, LPC **Date**