

**Adult Client Intake Form
Military Integrative Therapies
2106 Thoroughgood Rd
Virginia Beach, VA 23455
(757) 995-2196 Office
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**Kelly Andrews MS, LPC, RPT
Licensed Professional Counselor, Art, Play and EMDR 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 briefly explain what brings you to counseling.

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:

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

Date