Center Point

Adult Intake Form

The following form will become part of your confidential record. Please answer each question as completely and as carefully as you can.

Name: _____ Date of Birth: _____ Age: _____ Sex:_____

Street Address: _____ City & State: _____ Zip:_____

Contacts

May we contact you and leave messages on your…

☐Cell Phone Cell #:_____ ☐Text messaging ☐Home Phone: Home # _____

☐Email: _____

You are agreeing to the contacts indicated on this form as a means of contact by signing below:

_____ _____

Signature (client) (Date)

Employment Background Are you currently employed? Yes ❑ No ❑

Employer's Name: _____

Type of Work / Position:_____Length of time: _____

Personal Information

Who referred you to our office? _____

May we send them a letter of thanks? Yes ❑ No ❑

Describe any physical problems you have that require medication or physical care: _____

_____

How long ago was your last physical? _____

Are you currently receiving medical treatment? Yes ❑ No ❑

If yes, please explain: _____

Are you currently taking any prescription medication? Yes ❑ No ❑

If yes, please list:_____

SPIRITUAL BACKGROUND (Optional)

Are you a part of a local faith community? Yes ❑ No ❑ If so, which one? _____

How would you rate your current interest in spiritual growth?

1 2 3 4 5 6 7 8 9 10

◀——————————————————————————▶

No interest Not sure Very interested

Problem Areas

Place a check mark next to each item that identifies an area of concern to you. Place two checks next to those that are most important. Feel free to add additional comments.

- ☐ I have no problems or concerns
- ☐ Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence, threats
- ☐ Alcohol use
- ☐ Anxiety, nervousness, panic, tension
- ☐ Anger / Frustration, hostility, arguing, irritability, temper problems, self-control
- ☐ Career concerns, goals, choices, school
- ☐ Children, child management, child care, parenting, custody of children
- ☐ Codependence
- ☐ Confusion, thought disorganization
- ☐ Depression, low mood, sadness, crying
- ☐ Education
- ☐ Eating difficulties-overeating, under eating, appetite disturbance, vomiting, weight, diet
- ☐ Fearfulness
- ☐ Nervousness
- ☐ Memory problems
- ☐ Marital problems, conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Physical problems, health, illness
- ☐ Social relationships, interpersonal conflicts
- ☐ Impulsiveness, lack of control
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Judgment problems, risk taking
- ☐ Legal matters
- ☐ Problems with parents
- ☐ Low energy, motivation, laziness
- ☐ Low self-esteem, inferiority feelings
- ☐ Poor concentration, attention, distractibility
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Perfectionism
- ☐ Oversensitivity to rejection/criticism, shyness
- ☐ Headaches, other kinds of pains
- ☐ Gambling
- ☐ Fears, phobias, suspiciousness
- ☐ Fatigue, tiredness, low energy
- ☐ Failure
- ☐ Emptiness
- ☐ Guilt
- ☐ Sleep disturbances-too much/little, insomnia
- ☐ Irresponsibility
- ☐ Thoughts of hurting yourself
- ☐ Thoughts of hurting others
- ☐ Isolation / withdrawal
- ☐ Thoughts of suicide
- ☐ Drug use-prescription, over-the-counter, street
- ☐ Use of alcohol by family member / other
- ☐ Work / career
- ☐ Unpleasant thoughts won't go away
- ☐ Obsessive / compulsive behavior, compulsions
- ☐ Easily agitated / annoyed
- ☐ Loneliness
- ☐ Fatigue
- ☐ Difficulty trusting
- ☐ Trauma
- ☐ Sadness
- ☐ Stress, tension
- ☐ Heart pounding / racing
- ☐ Chest pain
- ☐ Trembling / shaking
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings

Signature: _____ Date: _____

* By signing here, I am consenting to allow this information to become a part of my clinical record and understand that it will be maintained in confidence by Center Point.