ADULT INTAKE EVALUATION

TO THE PATIENT: Your responses to the following questions will help your therapist better understand you and your situation in order to provide the best possible treatment. Please answer all questions as completely as possible.

IDENTIFYING INFORMATION

Name:____**D.O.B.:**________________**Age:**___________**Gender: F M**

Address:____**City**_________________________**Zip**________________

Home Phone:___________________________ **Work Phone:**_________________________ **Social Security#:**____-____-______

Cell Phone:_____________________________ **Email Address(es):** ____

Height:________________ **Weight:**___________________ **Eye Color:**__________________ **Hair Color:**________________

Marital Status: S M Sep. D W **Race:**___________________________ **Religion:**________________________________

Referral Source:____

Emergency Contact:_____________________________ **Phone:**_______________________ **Relationship:**________________

*****If you feel your therapist should be aware of any special considerations due to gender, age, sexual orientation, or cultural, religious, national, racial or ethical identity, please explain here:** ____

____

☐ **I would like to receive Lake Country Wellness& Counseling's Newsletter and event notification.**

PRESENTING PROBLEMS- Current Situation & History

1. **Please circle the main problem(s) for which you are seeking help:**
   - **a. Marriage**
   - **b. Family problems**
   - **c. Loneliness**
   - **d. Moodiness**
   - **e. Depression**
   - **f. Anxiety/Worry**
   - **g. Self-confidence**
   - **h. Memory**
   - **i. Alcohol/Drugs**
   - **j. Sex**
   - **k. Physical**
   - **l. Legal**
   - **m. Work**
   - **n. Eating Issues**
   - **o. Thought/attempts to hurt myself**
   - **p. Thought/attempts to hurt others**
   - **q. Other issues:**___________ ______________________
2. **When did the problems begin?**____
   ____
3. **How has it changed over time?**____
   ____
4. **Have your ever received treatment for this or other problems in the past? YES NO**
   If YES, when, where, and with whom?: ____
   ____

PSYCHOSOCIAL HISTORY

FAMILY HISTORY:

1. **Who raised you? (parent(s), grandparent(s), foster home(s), adoptive parents, siblings, etc):**_________________________
   ____
2. **Does anyone in the family you grew up in have an alcohol, drug, or mental health problem? YES NO**
   If YES, please indicate who, what problem and when, include any treatment information: ____________________________
   ____
3. **Do you need a referral for this person? YES NO**
4. **Did any type of abuse (domestic, emotional, physical, sexual) occur in the family you grew up in? YES NO**
   If YES, please describe the circumstances: ____
   ____

CURRENT FAMILY INFORMATION:

1. **Please provide the following information about your children (as applicable):**

Name	Age	Education	Occupation	Lives with You

2. **Are you having problems with your children? YES NO**
   If YES, please explain: ____
   ____
3. **Do you need a referral for your children? YES NO**
4. **Do you, your spouse/significant other have an alcohol or drug problem? YES NO**
   If YES, please indicate who, what problem and when; include any treatment information: ___________________________
   ____
5. **Have you, your spouse/significant other or your children ever been the victim of abuse (domestic, emotional, physical, or sexual)? YES NO**
6. **If YES, please explain:** ____
7. ____
8. **What is your occupation?** ____
9. **Education Level:**____

WORK HISTORY:

Employer	Position	Length of Employment

10. **Have you ever served in the military? YES NO**
    If YES, please explain: ____

MEDICAL HISTORY

1. **Please circle any of the following problems that you have now or have had in the past:**

Eye injury, disease or poor vision	**Liver, gallbladder diseases**	**Skin disease**
Ear injury, disease or poor hearing	**bowel problems**	**Back, arm, leg or joint problems**
Nose, sinus, mouth, or throat problems	**Hemorrhoids or rectal bleeding**	**Chest pain or angina pectoris**
Head injury	**Pregnancies not carried to term/stillbirths**	**Circulatory problems**
Convulsions or seizures	**Frequent or severe headaches**	**Heart disease**
Memory problems	**Sleep disturbances**	**Diabetes**
Neck stiffness, pain or swelling	**Extreme tiredness or weakness**	**High blood pressure**
Thyroid disease or goiter	**Marked weight changes**	**Blood disease**
Stomach trouble	**Allergies/asthma**	**PMS/Premenstrual Syndrome**

Please explain anything checked above: ____

____

Name and contact number of Primary Physician: ______________________________________

2. **Past or present illness (Check all that apply):**
   - ☐ **Meningitis** **Age:**__________ **Complications:**____________________
   - ☐ **Encephalitis** **Age:**__________ **Complications:**____________________
   - ☐ **Venereal Disease** **Age:**__________ **Complications:**____________________
   - ☐ **HIV/AIDS** **Age:**__________ **Complications:**____________________
   - ☐ **Hepatitis** **Age:**__________ **Complications:**____________________
   - ☐ **Tuberculosis (TB)** **Age:**__________ **Complications:**____________________
   - ☐ **Other:**________ **Age:**__________ **Complications:**____________________

   ***Risk Factors Discussed*:**____

3. **What prescription or over-the-counter medication(s) do you take?**

Medication	Dosage	Frequency	Prescribing Physician	Duration

4. Please list all psychiatric and medical hospitalizations, operations and injuries (including broken bones):

Where	Reason	When	Length of Stay	Doctor

COUNSELING/THERAPY GOALS

What important changes would you like to see as a result of counseling/therapy? Please list three changes, beginning with the most important to you:

1. ____

____

____

2. ____

____

____

3. ____

____

____

Please describe, from your viewpoint, how we will know when things are better?

____

____

____

____

____

Patient's Signature Date

____

Therapist's Signature Date