ADULT INFORMATION INTAKE FORM

Welcome to Christian Love Hutcheson Counseling Center. In order to serve you better, please take a few minutes to fill out the following information.

Full Name _____ Male ☐ Female ☐

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail Address _____

Employer _____ Occupation _____

Date of Birth _____ Age _____ Birth Order _____ # of Siblings _____

Education Level: GED ☐ High School Diploma ☐ College Degree ☐

Graduate Degree ☐ Current Degrees _____

May we have permission to:

Call you at your home? Yes ◯ No ◯ Leave a voicemail message? Yes ◯ No ◯

Call you at your office? Yes ◯ No ◯ Leave a voicemail message? Yes ◯ No ◯

Write you at your home? Yes ◯ No ◯ E-mail apt. reminders? Yes ◯ No ◯

Current Marital Status:

Never Married ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯

Name of Spouse (if applicable) _____

Employer _____Occupation _____

Date of Birth_____ Age _____ Birth Order _____ # of Siblings _____

Date of Marriage _____

Education Level: GED ☐ High School Diploma ☐ College Degree ☐

Graduate Degree ☐ Current Degrees _____

PREVIOUS MARITAL HISTORY:

Self:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children:

Name	Gender	Age	Father's/Mother's First Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HEALTH INFORMATION:

How would you rate your health? _____

How many hours do you sleep each night? _____

Do you experience food cravings? Yes ◯ No ◯ What items _____

How would you rate your diet? _____

Are you currently on any medications? Yes ◯ No ◯ Vitamins ☐

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS:

What are you seeking help for?

How much are you troubled by this?

Constantly ◯ Often ◯ Somewhat ◯ Not Very Much ◯

Has someone else requested that you see a counselor regarding this matter?

_____

Have you been in counseling before? Yes ◯ No ◯

If so, for each incidence, please complete the following:

1. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

2. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

THOUGHTS AND BEHAVIORS:

Please check how often the following thoughts occur to you:

1. Life is hopeless. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
2. I am lonely. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
3. No one cares about me. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
4. I am a failure. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
5. Most people don't like me. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
6. I want to die. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
7. I want to hurt someone. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
8. I am so stupid. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
9. I am going crazy. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
10. I can't concentrate. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
11. I am so depressed. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
12. God is disappointed in me. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
13. I can't be forgiven. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
14. Why am I so different? Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
15. People hear my thoughts. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
16. I can't do anything right. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
17. I have no emotions. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
18. Someone is watching me. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
19. I hear voices in my head. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯
20. I am out of control. Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯

Please comment with examples, frequency, duration, and effects regarding each of the above thoughts that concern you.

SYMPTOMS:

Please check the behaviors and symptoms that occur more often than you would like. Under to the symptom or behavior specify example or frequency.

☐ Aggression _____

☐ Fatigue _____

☐ Sexual Difficulties _____

☐ Alcohol Dependency _____

☐ Hallucinations _____

☐ Often Sick _____

☐ Anger _____

☐ Heart Palpitations _____

☐ Sleeping Problems _____

☐ Permissive Behavior _____

☐ High Blood Pressure _____

☐ Speech Problems _____

☐ Anxiety_____

☐ Hopelessness _____

☐ Suicidal Thoughts _____

☐ Avoiding People _____

☐ Impulsivity_____

☐ Thoughts Disorganized _____

☐ Chest Pain _____

☐ Irritability _____

☐ Trembling _____

☐ Depression _____

☐ Judgment Errors _____

☐ Withdrawing _____

☐ Disorientation _____

☐ Loneliness _____

☐ Worrying _____

☐ Distractibility _____

☐ Memory Impairment _____

☐ Dizziness _____

☐ Mood Shifts _____

☐ Drug Dependency _____

☐ Panic Attacks _____

☐ Eating Disorder _____

☐ Phobias/Fears _____

☐ Elevated Mood _____

☐ Recurring Thoughts _____

Whom should we contact in case of emergency?

Name_____

Address_____

Home Phone_____ Work Phone _____

Cell Phone_____ Relationship to you _____

Client Signature of Authorization to contact above person

_____

Thank you for choosing Christian Love Hutcheson Counseling Center
for your mental health care needs.