Welcome to Forster Counseling LLC. Please note that this information is important for your care. The information you provide here is protected as confidential information. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADULT INTAKE FORM

Name: ____

Date of Birth: ______________ Age: _______ ❒ Male ❒ Female

Address: ____

Home Phone: __________________ Can I leave a message? ❒ Yes ❒ No

Cell Phone: ____________________ Can I leave a message? ❒ Yes ❒ No

Email: ____ Can I email a message? ❒ Yes ❒ No

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the *main* reason you are seeking counseling: ____________________________

____

When did these symptoms first occur? ____

What would you like to see happen as a result of counseling? ____________________________

____

MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process

❒Separated ❒Widowed.

How many times have you been married? ______ Length of current marriage/relationship: _____

Assessment of current relationship if applicable: ❒ Poor ❒ Fair ❒Good

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, spouse, child, sibling)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

EDUCATION

Years of education completed: ______________

Currently enrolled in High School/GED? ❒ Yes ❒ No College? ❒ Yes ❒ No

Vocational? ❒ Yes ❒ No Graduate School? ❒ Yes ❒ No

Other training? ❒ Yes ❒ No If yes, what training? ____

MILITARY

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No

Where:_________________________________ Branch: ____

Length of service: ___________________ Type of discharge: ____________________________________

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful at when you try? ________________________

____

What personal qualities would others say you have? ____

____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) ____

____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No If Yes, where: ________________________________

Approximate Dates of Counseling: ____

For what reason did you go to counseling? ____

Do you have a previous mental health diagnosis? ____

What did you find **most helpful** in therapy? ____

____

What did you find **least helpful** in therapy? ____

____

Have you used psychiatric services? ❒ Yes ❒ No. If yes, who did you see? __________________________

If yes, was it helpful? ❒ Yes ❒ No Why? ____

Have you taken medication for a mental health concern? ❒ Yes ❒ No

Name of medication	Dates taken	Was it helpful? Y/N

Do you have other medical concerns or previous hospitalizations? ❒ Yes ❒ No

If so, please describe. ____

____

When was your last complete physical exam (month/year)? ______________________

How many times a week do you exercise? _________ What type and how many minutes: ____________

____

CHEMICAL USE AND HISTORY

Do you currently consume alcohol? ❒ Yes ❒ No

If yes, how often do you drink? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

If yes, how much do you drink? ___________(#) per time.

Do you currently use Tobacco? ❒ Yes ❒ No

If yes, how much do you smoke/chew/vape? ______________________

Do you currently use any other recreational drugs? ❒ Yes ❒ No

If yes, what drugs do you use? ____

If yes, how often do you use? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

Have you received any previous treatment for chemical use? ❒ Yes ❒ No

If so, where did you go?____

_______Inpatient ________Outpatient

Adults (*please answer the following with* **Y/N)**

1. Have you ever felt you ought to cut down on your drinking or drug use? ________
2. Have you ever had people annoy you by criticizing your drinking or drug use? _______
3. Have you ever felt bad or guilty about your drinking or drug use? _______
4. Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started? _______

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or have had a significant effect upon you in the past. ____

____

FAMILY HISTORY

What word would you use to describe your family of origin? ______________________

Did you experience any abuse or trauma as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable ______________

____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

____

____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above ____

____

____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
DISSOCIATION						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
DECREASED SEX DRIVE						EXCESSIVE WORRRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						DECREASED CREATIVITY				
ELEVATED MOOD						EASILY DISTRACTED				
MOOD SWINGS						TRAUMA FLASHBACKS				
DISORGANIZED						WORK ISSUES				
ANOREXIA						PROBLEMS AT HOME				
SOCIAL ISOLATION						PANIC ATTACKS				
PHOBIAS						FEELING ANXIOUS				
OBSESSIVE THOUGHTS						FEELING PANICKY				
GRIEF						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
LONELINESS						OTHER				

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? Who provides you emotional and/or other forms of support? ____________________________

____

____

ADDITIONAL INFORMATION

Is there anything else you would like to share:

____

____

____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

SIGNATURE_________________________________ DATE____________________