

CENTER FOR ANXIETY RELIEF AND EDUCATION, PLLC
Adult Intake and Psychosocial History

CLIENT INFORMATION

Client name _____ Date of birth _____ Current Age _____
Address _____ Gender Male Female
_____ Religion _____
Marital Status (Circle one) Married, Single, Separated, Divorced, Widowed
Phone (Home) _____ (Cell) _____
(Work) _____ Email _____
May we send an appointment reminder? Y / N
Confidential messages should go to: Home Work Cell Text Email
How did you hear about us? _____

EMERGENCY CONTACT

Name _____
Relationship _____ Phone _____

EDUCATION

____ Did not attend high school ____ Completed college/university ____ Some high school
____ High school Diploma ____ Some college/university ____ Completed graduate school

EMPLOYMENT

Status (Circle one): | Full time | Part time | Unemployed | Disability | Self-Employed | Retired |

Occupation: _____

Reason for unemployment (if applicable): _____

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MEDICAL HISTORY

Primary Doctor: _____ Phone: _____

Address: _____

Rate your overall health: Very Good Good Average Declining Poor

Outstanding health issues:

How is your appetite?

Are you presently taking any medication, including over the counter? (circle one): Yes / No

List medication(s) and Purpose:

Please list any current medical issues that impact your mental health: _____

Have you ever abused alcohol? _____ If yes when _____ Frequency of use _____

Have you ever abused drugs? _____ If yes when _____ Frequency of use _____

Are you a tobacco user? _____ If yes describe frequency _____

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PSYCHIATRIC HISTORY

Have you ever received any prior mental health treatment? Yes _____ No _____

If you answered yes please complete the following:

Name of provider /therapist

Period of treatment (date/year)

Previous diagnosis (include dates) _____

REASON FOR SEEKING COUNSELING

SYMPTOM ASSESSMENT

I AM EXPERIENCING.....	Seldom	Often	Always	Never	For how long?
Frequent worry or tension					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things Describe fear _____					
Panic attacks: sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” (reliving traumatic event)					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
Other:					

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I AM FEELING...	Seldom	Often	Always	Never	For how long?
Less interested in pleasurable activities					
Socially isolated, lonely					
Suicidal or have had suicidal thoughts					
Bereavement or Feelings of Loss					
My sleep patterns have changed (too much or not enough)-please circle one that applies					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
Other:					

Please identify symptoms that relate to the reason you are seeking counseling at this time:

I NOTICE.....	Seldom	Often	Always	Never	For how long?
I am angry, irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I oversleep					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE.....	Seldom	Often	Always	Never	For how long?
Trouble with memory and concentration					
Trouble explaining myself to others					
Difficulty comprehending others					
Intrusive or strange thoughts					
Obsessive thoughts					
Hearing voices when alone					
Seeing things that others don't see					
I HAVE.....	Seldom	Often	Always	Never	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward others					

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I AM HAVING DIFFICULTY ADJUSTING TO...	Seldom	Often	Always	Never	For how long?
Marriage					
Separation or Divorce					
Death of family, friend					
Career change					
Relocation					
Having children					
Blended family					
Other:					

Please identify symptoms that relate to the reason you are seeking counseling at this time:

I USE THE FOLLOWING SUBSTANCES.....	Seldom	Often	Always	Never	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Methamphetamines					

MY EATING INVOLVES.....	Seldom	Often	Always	Never	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					

MY SEXUAL CONCERNS INCLUDE....	Seldom	Often	Always	Never	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Other:					

EMPLOYMENT & SELF-CARE	Seldom	Often	Always	Never	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

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OTHER CONCERNS	Seldom	Often	Always	Never	For how long?
Gambling addiction					
Pornography addiction					
Chronic Illness, Terminal Illness					
Marital conflict					

Have you ever experienced anything you perceived as traumatic? Yes _____ No _____

If yes please describe. Examples: robbery, rape, death in family, domestic violence, sexual abuse, emotional abuse, physical abuse, severe injury, combat (*trauma can be either witnessed or experienced*).

FAMILY PSYCHIATRIC HISTORY

Does your biological mother have a history of mental or emotional problems or substance abuse? If yes, please explain.

Does your biological father have a history of mental or emotional problems or substance abuse? If yes, please explain.

Is your mother living or deceased? _____ If deceased what year? _____

Is your father living or deceased? _____ If deceased what year? _____

Has anyone in your family ever attempted or committed suicide? Yes ___ No ___

If yes who? _____ when? _____

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FAMILY HISTORY

Briefly describe your relationship with your mother (or mother figure):

Briefly describe your relationship with your father (or father figure):

Siblings:

Name	Age	Describe your relationship with sibling
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL/ SOCIAL HISTORY

Did you have any developmental or learning challenges when you were young? (Trouble in school, late reaching milestones, special education services, etc.)? Please describe.

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Have you ever been arrested, or been involved in a legal situation? Yes / No (Please describe.)

Please list hobbies or extracurricular interests you have.

What do you consider to be your strengths?

What areas you would like to improve upon?

If married/dating/living together, describe the current status of the relationship:

In what areas are you compatible (e.g., shared interests)?

In what areas are you incompatible (sources of conflicts)?

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PERSONAL/ SOCIAL HISTORY (continued)

Previous marriages for either? (If so, provide details)

Please list all marriages and children/stepchildren from each marriage.

Marriage (year)	Years married	Children Names	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly describe your relationship with your children

Who in your life provides you support when experiencing stress? (friends, family, etc.)

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CULTURE AND RELIGION/ SPIRITUALITY

Because we not only consist of a body, but body, soul and spirit, our spirituality therefore plays a major role in our lives. Although it isn't mandatory, we urge you to take the time to complete this section: (You may complete this or have the option for us to go through it together at a more convenient time).

What role does spirituality or religion play in your life?

How important was religion in your childhood? In what way?

What are the specific spiritual or religious values in your culture that you would identify as important?

What are the religious or spiritual values with which your current behavior is not aligned?

How do your religious or spiritual beliefs make you feel different from others?

At this particular time in your life, what are the issues related to your religious or spiritual beliefs that are being questioned by you or others? Why?

In what areas do individuals of your faith conflict with society? (In school, at work, etc)

What is your present religious program involvement (either locally or at home)?

