YOUR BEST LIFE NOW COUNSELING
1122 S. Dixie Highway
Radcliff KY 40160
270-307-0111
www.joshuasfriends.org

Adult Counselee Intake Form

Date ________________

Name ____
DOB ____________________

Address _______________________________ Apt. ___________________

City __________________________State ________ Zip __________

Work Phone _______________ Cell_________________ Home_______________

Employer/School ____

Occupation/Studying ____

Referral Information

Who referred you to me? ____

May I have your permission to thank this person for the referral?

Yes ______ No ______

Family Information

Relationship Status:

Single _____Married _____Partnered ____ Divorced _____Widow/Widower____

This is my: 1st ______2nd ______ 3rd ______ 4th _______ marriage/ partnership

Name (first only) of children and their ages:

1.________________________________3.______________________________

2.________________________________4.______________________________

Were your parents:

divorced _____never married ______still married ______ widowed _______

Where are you in the birth order of siblings in your family?

____

Family History of: (Circle all that apply)

Depression Suicide Attempts Anxiety Eating Disorders Mental Illnesses

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction

Chronic Illness

Please explain any chronic illness:_______________________________________

Other____

	First Name	Current age Or Age at Death	Illness/Cause Of Death	Occupation
Father				
Mother				
Step Parent				
Grandparents				
Uncles/Aunts				
Brothers				
Sisters				

Medical Information

Primary Physician______________________ Phone: _____________________

Date Last Exam ______________

Major or Chronic Illnesses/Injuries____

____

Operations:

____

____

____

____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have you experienced any recent changes in any of the following areas?

Sleep   Nightmares   Amount of Exercise   Sexual Desire   Eating/Appetite
Weight

How would you characterize your overall health?

Poor   Fair   Good   Excellent

Do you smoke? Yes ______ No ______ Smoked in the past? Yes _______ No___

Cigarettes/Day ______ Began at what age? ________ When did you quit?_____

Do you consume alcohol? Yes ___ No ____ If so, how much:

Less than 1x/month ____ 1-3x month ____1x week ____ several x's a week_____
Every day ______

Check all that apply: Beer ______ Wine ______ Hard Liquor _______

Do you use any street drugs or misuse prescription drugs? Yes _____ No _____
If yes, list as follows:

Name of Drug	Frequency of Use

Treatment Information

Please describe the main concerns that prompted your family to seek services at this time?

____

____

____

How have these concerns evolved over time?

____

____

____

____
____

____

Please indicate what major stressors you have had in the last 12 months

Serious illness or injury   Death of a Close Friend or Family Member

Major Illness in Family   Gain of New Family Member   Divorce/Separation

Job Change   Other ____

____

What you would like to be different in your life when you're done with counseling

____

____

____

Have you ever received psychological or psychiatric counseling before?

Yes _____   No ______

If so, please describe when, from whom, purpose and the results: _____________

____
____
____
____

Have you ever been prescribed medication for psychiatric or emotional problem(s)? Yes ______ No _______

If so, please describe when,

Prescribing Clinician	what medication	for what	the results

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes _______ No _______ If so, please describe

When	Where	For what Reason	Results

Have you been in a drug or alcohol program? Yes _____ No _____

If yes, how many times _____________

When	Inpatient	Outpatient	How Long	Outcome

Social/Relationship Information

Please indicate any of the following that you have experienced

Death of Mother Your age at time of death _________

Death of Father Your age at time of death _________

Death of Child Your age at time of death _________

Death of Sibling Your age at time of death _________

Desertion by Mother Your age at time of death _________

Desertion by Father Your age at time of death _________

Divorce of parents Your age at time of death _________

Sexual Abuse ______ Emotional Abuse_______ Physical Abuse __________

Violence in the Family _______ Mental Illness of Family Member ________

How do you get along with your present spouse or partner?

____

____

How do you get along with your children?

____

____

How do [or did] you get along with your family of origin?

Mother

____

Father

____

Siblings

____

Please list the first names of your significant friends and how long you have had these relationships:

First Name	How Long	How often do you see this person

Employment Information

What kind of job do you have? _______________________________________

How long at current job? ____

How satisfied are you in your job?

Not satisfied ____Somewhat satisfied ____Comfortable ____Very Satisfied______

Are you satisfied that the income from your job adequately covers your living expenses?

Not satisfied ___Somewhat satisfied ____Comfortable ____Very Satisfied______

Do you have other sources of income? Yes _____ No ______

If yes, please describe

____

Spiritual Resources

How significant a role does spirituality play in your life?

None _____ Somewhat important _____ Significant _____ Very Significant _____

Other

Is there anything else you think I should know about prior to beginning your treatment?

____

____

____

____

____

____

____

____

____

____

Thank you for your time. Our staff is looking forward to helping you.