4250 S. Westnedge Kalamazoo MI 49008
Email: counsel@awakeningscc.com Phone: 269-234-2343

Adult Intake Assessment

Name_____ Sex: M or F

Address_____ Date of Birth_____ Age_____

City_____ ST_____ Zip Code_____ Home Phone_____

Employer Work Phone_____

Email Address_____ Cell Phone_____

Marital Status (circle one): Single Married Separated Divorced Widowed

Emergency Contact_____ Relationship_____ Phone_____

INITIAL ASSESSMENT

Date_____

Your reason for seeking counseling: _____

_____

Is there anyone you want involved in your counseling? (ex: spouse, pastor, teacher, etc.) _____

EMPLOYMENT HISTORY

Current Employer _____Length of employment_____

Position/Title_____ Job satisfaction_____

LEGAL SYSTEM INVOLVEMENT

Have you ever been involved with the legal system? _____If yes, please explain_____

MILITARY HISTORY

Were you in the military service? Yes/No Branch Enlisted? _____Drafted?_____

Tour Dates _____Served _____Combat Yes/No Stationed_____

Disability or pension _____Type of discharge_____

EDUCATIONAL HISTORY

Highest grade completed?_____ Name of school_____

Area of study_____ Do/did you like school? _____Explain_____

Describe school performance _____

Have you ever been diagnosed with a learning disability?_____ Explain _____

Have you ever been diagnosed with ADD/ADHD? _____

MARITAL/RELATIONSHIP HISTORY

Current Spouse's Name _____ Age _____ Length of Marriage _____

Length of Engagement _____ Length of Dating Relationship_____

Were you previously married? Yes / No Was your spouse? Yes / No

BROTHER'S & SISTER'S (full or step or half)

Name

Age

Occupation

Marital Status

CHILDREN/STEP-CHILDREN

Name

Age

Relationship (child, stepchild, adopted)

Lives with you?

FAMILY HISTORY

Father's Name_____ Age_____

Education_____ Occupation_____

Mother's Name_____ Age_____

Education_____ Occupation_____

Marital status of parents:_____

Step Father's Name_____Age_____

Education_____ Occupation_____

Step Mother's Name_____ Age_____

Education_____ Occupation_____

Where were you born?_____ Who raised you?_____

Were you adopted? Yes No If yes, at what age?_____

FAMILY HISTORY (Cont.)

Have you or any member of your family experienced any of the following? (check all that apply)

ADDICTIONS

Alcohol: Who?_____

Drugs: Who?_____

Food/Eating: Who?_____

Gambling: Who?_____

Sex/Pornography: Who?_____

Relationship/Love: Who?_____

Other Who?_____

EMOTIONAL PROBLEMS

Depression: Who?_____

Anxiety: Who?_____

Panic Attacks: Who?_____

Manic/Depression: Who?_____

Obsessions: Who?_____

Suicide attempts or completion:_____ Who?_____

Phobia/fears: Who?_____

Anger/Explosive: Who?_____

Other: Who?_____

Have you or any member of your family been hospitalized for any of the above? Yes No

If yes, Who?_____

ABUSE: (to self/family member)

Physical: Self/Family?_____ by whom?_____

Emotional: Self/Family?_____ by whom?_____

Sexual: Self/Family?_____ by whom?_____

Spiritual: Self/Family?_____ by whom?_____

Did you ever witness violence in your home or elsewhere while growing up? Yes No If yes, explain_____

_____

_____

PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY

Physician's Name_____ Name of Practice_____

Address_____ Phone_____

Date of last visit_____ Reason_____

List any current or past medical conditions_____

List any surgeries and dates_____

List any abortion(s) and dates_____

List all current medications (dosage, frequency and purpose)_____

Do you drink alcohol?_____I f y es, how much and how often?_____

Do you smoke cigarettes or chew tobacco? _____I f yes, how much and how often?_____

Do you consume caffeine?_____ If yes, how much and how often?_____

List any allergies_____

List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.?

_____

PREVIOUS COUNSELING

Have you ever had formal counseling? _____How many times?_____

With whom?_____

When?_____Why?_____

Was it inpatient or outpatient?_____

Was it helpful?_____ Explain_____

Describe the last major change in your life_____

Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.)

_____

CURRENT SYMPTOM CHECKLIST:

Are you currently experiencing any of the following? Please "X" all that apply.

__Aggression

__Agitation

__Anger

__Anxiety/Nervousness

__Appetite Change

__Bad Dreams/ Nightmares

__Backaches

__Compulsions

__Change in Libido

__Crying/Tearful

__Cyber Addiction

__Delusions

__Depression

__Difficulty Getting out of Bed

__Difficulty Making Decisions

__Disorientation

__Distractibility

__Easily Annoyed

__Emotional Trauma Perpetrator

__Emotional Trauma Victim

__Eating Disorder

__Excessive Energy

__Elevated Mood

__Fatigue

__Grief

___Guilt

___Gambling

___Hallucinations

___Headaches

___Hearing Voices

___Heart Palpitations

___Hopelessness

___Hyperactivity

___Irritable Bowel

___Impulsivity

___Irritability

___Judgment Errors

___Loneliness

___Loss of Hope

___Loss of Interest in Activities

___Low Self-Esteem

__Memory Impairment

___Mood Swings

___Obsessions

___Oppositional Behavior

___Panic Attacks

___Paranoia

___Phobias/Fears

___Poor Concentration

___Poor Grooming

___Problems in Relationships

___Physical Trauma Perpetrator

___Physical Trauma Victim

___Racing Thoughts

___Recurring Thoughts

___Restlessness

___School Problems

___Social Withdrawal

___Seizures

___Self-Mutilation

___Sexual Addiction

___Sexual Difficulties

___Sleep Problems

___Speech Problems

___Sexual Trauma Perpetrator

___Sexual Trauma Victim

___Social Isolation

___Substance Use

___Suicidal Thoughts

___Trouble Concentrating

___Trouble Sleeping

___Violent Thoughts

___Weight Loss or Weight Gain

___Work Problems

___Worthlessness

___Worried

HISTORY

Do you have people in your life that you consider close friends?_____

When going through a difficult experience in your life do you have someone to confide in?_____

What activities/hobbies do you enjoy participating in?_____

Are you a member of any groups or organizations?_____ Explain_____

List two strengths about yourself_____

List two things about yourself that you would like to change?_____

SPIRITUAL HISTORY

Are you affiliated with a church? _____If yes, which church? _____

Address_____ Phone_____

How involved are you in the congregation?_____

Attendance: Never_____ Sometimes _____Regularly_____

ADDITIONAL INFORMATION

What else should your therapist know about you?_____

Therapist Date of assessment review

Date: _____