# SOLACE CENTER
## Adult Intake Form

Name: _____ Age: _____ Gender: _____ Birth Date: _____

Home Address: _____ City: _____ , ____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Cell Phone: _____ Where may we leave a message for you? _____

Employer: _____ Occupation: _____

Who referred you? _____

**Marital Status**: (currently)

_____Single
_____Married / How long: _____ _____Unmarried, living together / How long: _____
_____Divorced / How long: _____ _____Widowed / How long: _____

**Family Structure:**

| Relationship | Name | Age | Living Yes | Living No | Living with you Yes | Living with you No |
|---|---|---|---|---|---|---|
| Spouse | _____ | _____ | ____ | ____ | ____ | ____ |
| Children | _____ | _____ | ____ | ____ | ____ | ____ |
| | _____ | _____ | ____ | ____ | ____ | ____ |
| | _____ | _____ | ____ | ____ | ____ | ____ |
| | _____ | _____ | ____ | ____ | ____ | ____ |
| | _____ | _____ | ____ | ____ | ____ | ____ |

**Counseling History**:

Are you receiving counseling services at the present? _____Yes _____No

If yes, where: _____ For what reason: _____

Have you received counseling in the past? _____Yes _____No

If yes, where: _____ For what reason: _____

What is the main reason for this visit? _____

How long has it persisted? _____

Under what conditions does your problem get better? _____

_____

Under what conditions does your problem get worse? _____

_____

**Medical**:

Primary care physician: _____ City: _____

Average hour of sleep per night: _____ Is that more, less or the same as usual? _____

Is your appetite more, less or the same as usual? _____

Have you lost interest in the things that you normally enjoy? _____Yes _____No

What medications are you taking and for what purpose?

| Medication | Purpose |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family of Origin**:

Which best describes the family in which you grew up?

Warm and Accepting Average Hostile and Fighting

1 2 3 4 5 6 7 8 9 10

Which best describes the way in which you were raised?

Allowed Me Independence Average Controlled Me

1 2 3 4 5 6 7 8 9 10

**Your Mother**

Briefly describe your mother:

_____

_____

_____

How did you get along with her when you were a child?

_____

_____

_____

How do you get along with her now?

_____

_____

_____

Did your mother have any problems that effected your childhood (alcoholism, violence, abuse, etc.)?

**Your Father**

Briefly describe your father:

How did you get along with him when you were a child?

How do you get along with him now? _____

Did you father have any problems that effected your childhood (alcoholism, violence, abuse, etc.)?

**Personality**:

List your greatest strengths:

List your greatest weaknesses: _____

List your main relationship / social difficulties:

List your main love and sex difficulties:

_____

List your main difficulties at work or school:

_____

_____

_____

List your main difficulties at home:

_____

_____

_____

**Symptoms and Behaviors**:
Check the symptoms and behaviors that are a concern to you:

_____Aggression
_____Alcohol dependence
_____Anger
_____Antisocial behavior
_____Anxiety
_____Avoiding people
_____Chest pains
_____Depression
_____Disorientation
_____Distractibility
_____Dizziness
_____Drug dependence
_____Eating disorder
_____Elevated mood/manic
_____others _____

_____Fatigue
_____Hallucinations
_____Heart palpitations
_____High blood pressure
_____Hopelessness
_____Impulsivity
_____Irritability
_____Judgment errors
_____Loneliness
_____Memory impairment
_____Mood shifts
_____Panic attacks
_____Phobias/fears
_____Recurring thoughts

_____Sexual difficulties
_____Sick often
_____Sleeping problems
_____Guilt
_____Suicidal thoughts
_____Disorganized thoughts
_____Trembling
_____Withdrawing
_____Worrying
_____Thoughts of killing
_____Cyber addiction
_____Gambling
_____Sexual addiction