**The Healing Place**

**Adult Intake Form**

# I. GENERAL INFORMATION Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth: |  |
|  |  |  |  |
| Phone Number: |  | Email Address: |  |
|  |  |
| Home Address: |  |
|  |  |  |  |
| Languages Spoken: |  | Ethnic/Cultural Identity: |  |
|  |  |
| Gender Identity: | [ ]  Female [ ]  Male [ ]  Non-Binary [ ]  Transsexual [ ]  Other |
|  |  |
| Marital Status | [ ]  Single [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed |
|  |  |
| Emergency Contact: | Name:  |  | Phone Number: |  |

**II. REFERRAL INFORMATION**

|  |
| --- |
| Please describe the main reason you are requesting therapy services in the space below:  |
|   |

**III. FAMILY RELATIONSHIPS (Please identify all of the people that live with you below)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Name* | *Sex* | *Age* | *Relationship to You**(i.e. person is my son, partner, etc.)* | *Please list any concerns or conflicts you have with this person* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**IV. MEDICAL HISTORY**

|  |  |
| --- | --- |
| Do you have any physical disabilities? | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |
| Are you currently experiencing any major medical problems?  | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |
|  |  |  |  |
| Are you currently taking any medication(s) regularly? | [ ]  Yes [ ]  No |
| If yes, please list out all the medications using the chart below: |
| Medication Name | Dosage | Purpose | Prescribing Physician |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**V. EDUCATIONAL & JOB HISTORY**

|  |  |
| --- | --- |
| Did you graduate from High School?  | [ ]  Yes [ ]  Earned a GED [ ]  No |
|  |  |  |
| Are you currently enrolled in a college? | [ ]  Yes [ ]  No  |  |
| If yes, where and what are you studying:  |  |
|  |  |
| Do you have any degrees? | [ ]  Yes [ ]  No  |
| If yes, please list them:  |  |
|  |  |
| Are you currently employed: | [ ]  Yes [ ]  No  |
| If yes, please describe the occupation: |  |
|  |  |
| Are you experiencing any significant conflict or stressor at your workplace? | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |

**VI. SOCIAL HISTORY**

|  |  |
| --- | --- |
| How many friends did you have in childhood?  | [ ]  Many [ ]  Few [ ]  None |
|  |  |  |
| How many friends did you currently have?  | [ ]  Many [ ]  Few [ ]  None |
|  |  |
| Are you actively participating in any social activities? | [ ]  Yes [ ]  No  |
| If yes, please list them:  |  |
|  |  |
| Do you have a religious affiliation | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |
| How frequently do you attend religious services? | [ ]  Regularly [ ]  Sometimes [ ]  Never  |
|  |  |
| Are you currently experiencing any major social conflict? | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |

**VII. SEXUAL HISTORY**

|  |  |
| --- | --- |
| Which of the following best describes your sexual identity? | [ ]  Heterosexual [ ]  Bisexual [ ]  Homosexual [ ]  Asexual [ ]  Other |
| Are you in a sexual relationship(s) now? | [ ]  Yes [ ]  No  |
| If yes, please describe with whom: |  |
|  |  |
| Are you currently experiencing any sexual problems? | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |

**VIII. PSYCHOLOGICAL HISTORY**

|  |  |
| --- | --- |
| Have you ever been treated by a psychiatrist before? | [ ]  Yes [ ]  No |
| If yes, please briefly describe diagnosis made and treatment recommendations given: |
|  |
| Are you still receiving treatment from a psychiatrist? | [ ]  Yes [ ]  No  |
|  |  |
| Have you ever been treated by a therapist/counselor before? | [ ]  Yes [ ]  No |
| If yes, please briefly describe diagnosis made and treatment recommendations given: |
|  |
| Are you still receiving treatment from a therapist/counselor? | [ ]  Yes [ ]  No  |
|  |
| Have you ever experienced what you would consider “abuse”? | [ ]  Yes [ ]  No  |
| If yes, please check all that apply? | [ ]  Physical [ ]  Emotional [ ]  Sexual [ ]  Neglect [ ]  Financial  |
| If yes, please describe any details you are comfortable sharing: |
|  |
| Have you ever attempted suicide? | [ ]  Yes [ ]  No  |
| If yes, please share the number of times, the circumstances of the attempt, and what medical/psychological treatment was received afterwards (if any): |
|  |
| Have you ever purposely hurt your body in any way? | [ ]  Yes [ ]  No  |
| If yes, please share the number of times, the circumstances of the self-harm, and what medical/psychological treatment was received afterwards (if any) |
|  |
| Are you currently having any thoughts of hurting yourself?  | [ ]  Yes [ ]  No  |
| If yes, please describe any details you are comfortable sharing: |  |
|  |
| Are you having any thoughts of hurting or killing others? | [ ]  Yes [ ]  No  |
| If yes, please describe: |  |
|  |  |
| Has anyone in your family ever been diagnosed with an emotional or psychological disorder?  | [ ]  Yes [ ]  No  |
| If yes, please explain: |  |

**IX. SUBSTANCE ABUSE HISTORY**

|  |  |
| --- | --- |
| Do you use any of the following substances? | If yes, how frequently do you use this substance? |
| Alcohol | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Cigarettes | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Stimulants / Cocaine | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Hallucinogens/ LSD | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Inhalants/ Poppers | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Marijuana | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Methamphetamines | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Opiates/Heroine | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Pharmaceuticals | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
| Other | [ ]  Yes [ ]  No | [ ]  Rarely [ ]  Occasionally [ ]  Weekly [ ]  Daily |
|  |  |
| Has the use of any of the above substances been a concern for you? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |
| Have you ever quit or tried to reduce use any of the above substance? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |
| Have you ever participated in a substance rehabilitation program? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |
| Does anyone in your family have a drug or alcohol problem? | [ ]  Yes [ ]  No |
| If yes, please describe: |
|  |

**X. LEGAL HISTORY**

|  |  |
| --- | --- |
| Have you ever been arrested? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Have you ever been sentenced to jail or prison? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Are you currently on any kind of probation or parole? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |
| Are you currently a party or plaintive to a lawsuit? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |
|  |  |
| Do you have any protective orders for or against you? | [ ]  Yes [ ]  No |
| If yes, please describe: |  |

**XI. MAJOR LIFE EVENTS**

|  |
| --- |
| In the past year, have you experienced any of the following major life events? |
| Event |  | If yes, please explain when & how you feel about the event: |
| Marriage | [ ]  Yes [ ]  No |  |
| Death of a Loved One | [ ]  Yes [ ]  No |  |
| Divorce/Separation | [ ]  Yes [ ]  No |  |
| Moved (# of times\_\_\_) | [ ]  Yes [ ]  No |  |
| Domestic Violence | [ ]  Yes [ ]  No |  |
| Birth of a Baby | [ ]  Yes [ ]  No |  |
| Miscarriage/Abortion | [ ]  Yes [ ]  No |  |
| Loss/Change of Employment | [ ]  Yes [ ]  No |  |
| Victim of a Crime | [ ]  Yes [ ]  No |  |
| Witness to a Trauma | [ ]  Yes [ ]  No |  |
| Exposure to Warfare | [ ]  Yes [ ]  No |  |
| Other? | [ ]  Yes [ ]  No |  |
| Is there anything else that was not asked that is important for me to know about you or that you would like me to be aware? |
|  |

# XII. THANK YOU!

Thank you for taking the time to complete this form. You may email the form back to me at sparks@TheHealingPlaceTherapy.com or bring a completed copy with you to our next appointment.

This information is important for me to ensure that I provide the best services to you. I assure you that all your information will remain confidential as part of your treatment record. As an adult only you or a legal guardian have access to the record upon request. Please note, that this record along with other documentation about services rendered may be subpoenaed by a court of law. If the record is subpoenaed you will be notified and informed of your rights. If you have any questions or concerns you may contact Steven Parks at 979-464-977 or email TheHealingPlaceTherapy@gmail.com