**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](mailto: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](mailto:TheHealingPlaceTherapy@gmail.com)