ALMA MILLER COUNSELING

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CONFIDENTIAL

ADULT INITIAL INTAKE FORM

(*1 Per Person for Families & Couples*)

Please provide the following information. It is essential that you are as accurate and truthful as possible.

Client Personal Information

Name: _____ DOB:_____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____OK to text? _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of Driver's License or other ID ☐

Significant Other Personal Information (Couple/Family counseling only)

Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____OK to text?_____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of Driver's License or other ID ☐

Referral Source:

If referred, list group or person that referred you to counseling: _____. Were you referred specifically to Alma Miller for counseling? ( ) Yes ( ) No

Annual household income(optional): _____ Currently meeting your bills? ( ) Yes ( ) No

Family Information

People living in the home:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Relationship Status:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) asexual ( ) other _____ ( ) unsure/questioning ( ) prefer not to answer

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long was each marriage? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender:
_____
_____

Medical History
Allergies_____ Current Weight _____ Height _____

List **ALL current prescription medications** and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date
_____
_____
_____
_____
_____

Current **over-the-counter** medications or supplements:
_____
_____
Current medical problems:
_____
_____
Past medical problems, non-psychiatric hospitalization, or surgeries:
_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____. Was it normal? ( ) Yes ( ) No

For women only:
Date of last menstrual period _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( )No
Date and place of last physical exam: _____

Current Physician: _____ Phone: _____

Personal and Family Medical History (Include current and past medications:

_____
_____
_____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____
_____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( )Yes ( )No Depression ( )Yes ( )No Anxiety ( )Yes ( )No Anger ( )Yes ( )No

Suicide ( )Yes ( )No Schizophrenia ( )Yes ( )No Post-traumatic stress ( )Yes ( )No

Alcohol abuse ( )Yes ( )No Other substance abuse ( )Yes ( ) No Violence( )Yes ( )No

If yes, who had each problem?

_____
_____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?

_____
_____
_____

Has a relative ever been **hospitalized** for drug or alcohol use, or mental or emotional difficulties?

_____
_____
_____

Personal Mental Health History:
Have you had counseling in the past? ( ) yes ( ) no
Are you currently involved in any other counseling, including lay counseling, spiritual counseling and or professional counseling? ( ) yes ( ) no
Current or past mental health diagnoses, date of diagnosis, and by whom::

_____
_____

Intensive outpatient treatment? ( ) Yes ( ) No If so, When _____
Where? _____

Psychiatric Hospitalizations? ( ) Yes ( ) No If so, When: _____
Where? _____

Drug and Alcohol Treatment/hospitalizations? ( ) Yes ( ) No If so, When : _____
Where? _____

Caffeine Usage:
How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____
Energy Drinks _____

Tobacco History:
Have you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____
In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average? _____ How many years? _____

Alcohol and/or drug use:
Do you drink alcohol? ( ) Yes ( ) No How often? _____
Type?( )Wine( )Beer ( )Liquor( )Other _____

Are any family or friends concerned about your drinking? ( ) Yes ( ) No Explain:
_____
_____
Are you concerned about your drinking? ( ) Yes ( ) No Explain:
_____
_____
Do you use illegal/prescription Drugs (including Marijuana)? ( ) Yes ( ) No

If so, which ones and how often?
_____
_____
_____

How many hours of sleep to you normally get each night? _____ Hours

Your Exercise Level:
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Education History: Provide highest level of education completed and any other relevant information.
_____
_____
_____
_____

Trauma History:
Do you have a history of abuse; emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

Legal History: (*including Probation information and Military history***)**
Have you ever been arrested? ( ) Yes ( ) No
Are you currently involved in pending court cases or legal problems? _____
_____

Past legal situations:

_____

_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
Name of congregation and denomination: _____

If yes, what is the level of your involvement? _____
Do you find your involvement helpful, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Mental Status Information
Are you currently thinking about suicide or harming yourself in any way? ( )Yes ( )No

Have you had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ( ) Yes ( ) No

Are you having thoughts about harming anyone else in any way? ( )Yes ( )No

Have you ever experienced any form of auditory or visual hallucinations? ( )Yes ( )No

Counseling Information:
Chief Complaint (the major reasons for needing counseling). Please also include any current symptoms—including social, emotional, physical, spiritual.

_____
_____
_____
_____
_____
_____
_____

Describe what has already been done to try and resolve the situation:

_____
_____
_____
_____

What do you hope for in resolving the situation? What will be different? _____
_____
_____
_____