

ALMA MILLER COUNSELING

Alma Miller MA, LMFT, LPC

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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

Family of Origin: Do you have siblings? () Yes () No

If yes, please share sibling order & ages:

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? _____
