

**Cord of Three Counseling Services
Individual Adult Intake Form**

Client Home Phone _____	Client Cell Phone _____
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BACKGROUND INFORMATION

Client Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Employer: _____ Occupation: _____

Email: _____ Home Phone: _____

Emergency Contact Person: _____ Emer. Contact #: _____

Client Age: _____ Client Gender: _____ Client Ethnicity: _____

Church of Attendance: _____ Active Member: Yes No

Presently living with:

- Parents
- Spouse
- Roommate
- Alone
- Other _____

Marital Status:

- Single
- Married
- Separated
- Divorced
- Widowed
- Other _____

Highest Education Completed:

- Elementary School
- High School
- College
- Graduate School
- Professional School
- Other _____

If you are or have been divorced or are separated, please explain the situation.

Please write in black ink.

Chief Complaint (What are the primary problems that have caused you to seek out counseling at this time?)

Have you ever received any previous counseling/psychiatric or substance abuse treatment?

TX PROVIDER/ FACILITY NAME	DATE	REASON FOR TREATMENT	LEVEL (check one)			
			Inpatient	Partial	Residential	Out Pt
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY: (Please check any of the following medical problems you have experienced)

- | | | | | |
|--|---|--|---------------------------------------|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowels | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Liver | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Kidney | <input type="checkbox"/> Gynecological | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Neurological exam | | |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizures, type: _____ | | | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis, type: _____ | | | |
| <input type="checkbox"/> Other : _____ | | | | |

MEDICATIONS: (All Current Medications You Are Taking)

Current Medications	Dosage/Frequency	Prescribed by	Last use	Is medication being taken as prescribed?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

List all allergies (include medications, foods, insects, substances, & any others):

Please list all health care providers treating you at this time: _____

Physical Pain Screening:

Please circle the face that corresponds to your level of physical pain today.



If you have physical pain today, describe what is causing your pain:

Have you talked with your medical doctor about your pain?

LEGAL STATUS ASSESSMENT:

Please provide an explanation of any legal involvement:

Are there any current/pending legal problems? YES NO

Are you on probation/parole? YES NO (If yes, P.O.'s name & phone)

Do you have previous legal history?

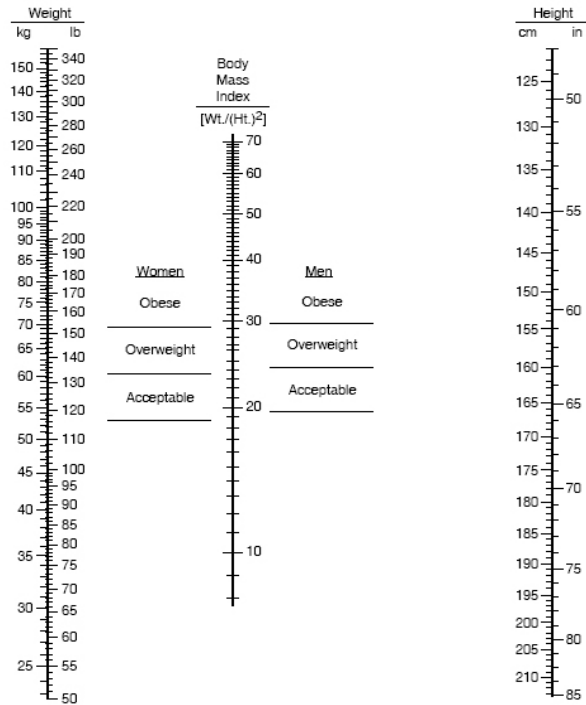
YES NO

Will legal situation impact treatment?

YES NO

Nutrition Screening:

Please mark your height in inches and your weight in lbs.



Please Circle each number if you answer yes to any of the questions below:	Yes
I have lost or gained 10 lbs. in past 6 months	2
I do not have enough food to eat each day	1
I do not eat 1 or more days each month	2
I have an illness that has made me change the kind and/or amount of food I eat	1
I eat fewer than 2 meals per day	1
I eat few fruits or vegetables or milk products	1
I have 3 or more drinks of beer, liquor or wine each day	2
I have tooth or mouth problems that makes it hard to eat	1
I don't always have enough money to buy the food I need	1
I eat alone most of the time	1
I have a history of bingeing and/or purging	2
I exercise excessively to maintain weight	2
I am anorexic	2
0 – 2 Good! 3 – 7 You are at moderate nutritional risk: See what can be done to improve your eating habits and lifestyle. 8 or more You are at high nutritional risk: You may need to be under the help of a qualified medical doctor or counselor.	

ALCOHOL/DRUG HISTORY:

Any History of drug/alcohol use? YES NO If NO, go to Psychosocial History.

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Hallucinogens (Acid/LSD) | <input type="checkbox"/> Methadone | <input type="checkbox"/> Pain Medications |
| <input type="checkbox"/> Crack | <input type="checkbox"/> Opiates | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Over-the-counter Medications |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Heroin | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Crank |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Methamphetamine (Ecstasy, crystal meth) | |

Other: _____

COMPLETE THE FOLLOWING FOR THE ITEMS CHECKED ABOVE:

Substance Checked	Amt/Frequency	Duration of Use	First Use	Last Use	Amt. used in last 24 hours

Withdrawal Symptoms/behaviors from alcohol/drug use: (Check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Aggression/assaultive | <input type="checkbox"/> Cramps | <input type="checkbox"/> Agitation | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Profuse sweating | <input type="checkbox"/> Change in blood pressure | <input type="checkbox"/> Tingling | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Delirium | <input type="checkbox"/> Anorexia | <input type="checkbox"/> None |

Please complete all 4 pages!

PSYCHOSOCIAL HISTORY:

Describe your leisure and recreational activities:

What type of social activities do you participate in?

Have you ever been a victim of physical/sexual abuse? YES NO

Are you sexually active? YES NO

Have you ever physically or sexually abused another person? YES NO

SUPPORT SYSTEMS

(availability of family/friends to participate in treatment, special family concerns)

LIST OF PEOPLE LIVING IN THE HOME, NOT INCLUDING YOURSELF:

NAME	RELATION TO CLIENT	AGE	GENDER	OCCUPATION

Do you want your significant other or anyone in your family to participate in your treatment?
If so, who?

REVIEW OF COMMUNITY RESOURCES

(check all that apply now or that you have used in the past):

- Church Health Dept Medical Clinics Voc. Rehab Adult Ed.
- Housing Schools SSI/Medicaid SSA/Medicare Food Stamps/WIC
- Child Insurance Family/Friends Financial Aid
- DFCS: Name of current case worker
- Other community resources (please specify):

Safety Risk Screening:

Please Circle the number to the left if any of the following are true:	
Risk Factors	
1	Current/past psychiatric diagnosis: I have been diagnosed with a mood disorder, psychotic disorder, alcohol/substance abuse addiction.
1	Key Symptoms: I experience any of the following symptoms: depression, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
2	Suicidal Behavior: I have a history of past attempts of suicide or self-injurious behaviors
1	Family: I have a family history of suicide or suicide attempts and/or a family history of mental health problems
1	Precipitating Factors: I have experienced public humiliation, shame or despair (i.e. loss of relationship, financial problems, health status changed) or I have been diagnosed with an ongoing medical illness
1	I have access to firearms
Protective Factors	
-1	I have the ability to cope with stress and I have religious beliefs against self-harm
-1	I have a responsibility to my children or loved ones and I have positive outlets for expressing myself and being understood
Suicide Inquiry	
2	I have a been thinking about suicide during the past <input type="checkbox"/> 48 hours <input type="checkbox"/> month <input type="checkbox"/> Year
2	I know when, how and where I would commit suicide
2	I have attempted suicide in the past and I have rehearsed (literally or in my mind) how I would commit suicide or hurt myself
2	I have a desire to physically hurt someone else

Risk Level Score: _____

Please complete all 4 pages!

Please check any of the symptoms listed below which apply to you:

	Current	History	N/A
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic thought/behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganized/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binging/Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractibility/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying/Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Truancy/Absenteeism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property Destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other legal Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Religious/Spiritual Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk of Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you hope is changed as a result of coming to counseling?

Any other information you would like for your counselor to know?