CONNECTIONS THERAPY CENTER

Adult Intake

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Marital Status: single engaged married remarried separated divorced widowed

Sexual Orientation (optional): ________________________ *Gender Identification (optional):* ______________

Presenting Problem - Describe your primary concerns: ____

____

____

Please indicate the severity of your problem on a scale from 0-10. Zero is mild and ten is very severe.

0 1 2 3 4 5 6 7 8 9 10

FAMILY DATA:

Does your spouse or romantic partner live with you? Yes No

Name: __________________________________ *Age:* ________ *Occupation:* ________________________

Describe your relationship with your spouse or romantic partner: ____________________________________

____

Children: list the name, sex, age.

1. ____________________________ *2.* _______________________________ *3.* _______________________

4. ____________________________ *5.* _______________________________ *6.* _______________________

Describe your relationship with your children? ____

____

List anyone else who lives with you? ____

____

Father: living or deceased If deceased, age at death __________ *Cause of death* ______________________

Occupation? ___________________ *If living, present age* ______________ *Health:* _____________________

Describe your relationship with your father? ____

____

Mother: Living or deceased If deceased, age at death __________ *Cause of death* ______________________

Occupation? ______________________ *If living, present age* ________________ *Health:* ___________________

Describe your relationship with your mother? ____

____

Siblings: # of brothers? __________ *Ages:* ______________ *# of sisters?* __________ *Ages:* ______________

Describe your relationships with your siblings? ____

____

How were you disciplined as a child? ____

Languages spoken in your home: ____

Does any member of your family have a past or present history of chronic illness? _______________

*Is there any history of genetic disorders in the family?*_______________________________________

Has any family member had a language or speech problem? ___________________________________

Has any family member experienced emotional problems? *Yes* *No* *Committed suicide?* *Yes* *No*

____

Has any family member experienced problems with alcohol or drugs? ______________________________

Has any family member been hospitalized for psychological reasons? _____________________________

EDUCATIONAL HISTORY

Highest grade completed: _____ *Last school:* __________________ *Did you repeat any grade?* *Yes* *No*

Highest degree attained: *GED* *HS diploma* *Associate's* *Bachelor's* *Master's* *Doctorate*

Did you receive any special services inside or outside of school? *Yes* *No* *Describe:*

____

____

Were you ever placed on probation, suspended, or expelled from school? *Yes* *No*

Please explain ____

Best Subjects? ____ *Grades in these subjects?* _______________

Worst subjects? ____ *Grades in these subjects?* _______________

MEDICAL HISTORY

Physician's name: ___________________________ *Phone:* _________________*Date of last physical?*___________

Height: ____ Weight: ____ Do you exercise? Yes No How Often? ____________________

Any recent weight gain or loss? Yes No ____

List illnesses, injuries, hospitalizations, or surgeries during childhood or adolescence: ____________________

____

List illnesses, injuries, hospitalizations, or surgeries during adulthood: ________________________________

____

Have you ever had a head injury or been knocked unconscious? Yes No

List current medications: ____

____

List current allergies or health problems:

____

How many meals per day? ______________________ Any changes in eating habit? ____________________

How many hours do you sleep at night? ______________ Any changes in sleeping habit? ______________

Do you drink alcohol? __________ How often? _____________ How much? __________________________

Do you use drugs? Yes No How often? _______ How much? _______________________________

Have you had a psychological or psychiatric evaluation? Yes No Explain: ______________________

____

Have you ever been in counseling? Yes No Was it helpful? _________________________________

Have you ever taken medication for psychological problems? Yes No Types:

OCCUPATIONAL HISTORY

Employer: ________________________________Job Title: ___________________ How long? ____________

Address: ____

Are you satisfied with your present work? Why? ____

What are your career goals? ____

Have you ever been fired from a job? Yes No Please explain: ____________________________________

____

What kind of jobs have you had in the past? ____

SOCIAL HISTORY

Religion (optional) a) in childhood: ________________________ b) as an adult: ________________________

How many friends do you have that you can count on or confide in? ____________________________________

Do you have problems making or keeping friends? Yes No Explain:______________________________

____

Have you ever been bullied or severely teased? Yes No Explain: ______________________________

____

When you were a child, did anyone ever touch you in a sexual manner? Yes No

Who? __________________ How old were you? ________ How many times did it happen? _______________

Have you ever been physically assaulted or beaten up? Yes No

By whom? ______________ How old were you? _________ How many times did it happen? _______________

Have you ever been forced to have sex against your will? Yes No

By whom? _____________ How old were you? __________ How many times did it happen? _______________

Have you ever had an experience where you were afraid for your safety or the safety of someone close to you?

Yes No Explain: ____

Have you ever been in trouble with the law? Yes No Explain: ________________________________

____

What are your hobbies and interests? ____

____

Additional information you feel your therapist should know:____

____

____

TREATMENT PLAN

Name: ____

Diagnosis : ____

____

____

Plan:

A. Goals

1. ____
2. ____
3. ____

B. Planned Interventions (must address goals set above).

1. ____
2. ____
3. ____

C. Objective Outcome Criteria (by which goal achievement is measured).

1. ____
2. ____
3. ____

______________________________ ______________________________

Client or Legal Representative Date

______________________________ ______________________________

Therapist Signature Date

_______ copy provided to client