nCenter
1043 Stoneridge Dr. Ste 2
Bozeman, MT 59718-7084
406-599-2492

Adult Intake Part 1: Client History

Note: This is a confidential document between you and your counselor. Your first counseling session will be an opportunity to go over your intake documents and hear your concerns.

Instructions: Please answer each question completely and legibly. If you need more space, use the additional comments section on the last page or write on the back of the page. If a question does not apply to you, write n/a. If you have any questions, please call (406) 599-2492.

Demographics

Client Name: _____ DOB: _____ Gender: _____

Presenting Problem

What brings you into therapy? How is this affecting your life?

_____

_____

_____

_____

History of Problem

How long have you been dealing with this? Any thoughts on why this is going on for you? How have you tried to cope with this so far?

_____

_____

_____

_____

Treatment History

Have you had previous therapy? If yes- when, with whom, and how was the experience?

_____

_____

_____

Has there been any past use of psychiatric medications? If yes, please list:

_____

_____

Family/ Social History

Family relationships: Mother, Father, Siblings (and birth order)?

_____

_____

_____

Are there any significant family issues?

_____

_____

_____

_____

Single, married, divorced, separated?

_____

_____

Do you have any children? If yes, include names and ages:

_____

_____

Any guardianship/ custody issues? Social service involvement?

_____

_____

What kind of support do you have? Friends, family, school, community, religious?

_____

_____

_____

History of Trauma (emotional, physical, sexual abuse, or abandonment), exposure to violence, significant deaths and/or losses?

_____

_____

_____

Familial mental illness, depression, suicide, substance/alcohol abuse?

_____

_____

_____

Family legal difficulties/ incarcerations?

_____

_____

_____

Ethnicity/ cultural influences past and present:

_____

_____

_____

Religious/ spiritual influences past and present:

_____

_____

_____

Recreation: Include any interests, hobbies, relaxation, or fun activities:

_____

_____

_____

Psychological History

History of depressed mood, suicidal thoughts, or thoughts of hurting self or others?

_____

_____

_____

History of anxiety and/or worry:

_____

_____

_____

History of irritability, anger or violence:

_____

_____

_____

Sleep: normal, sleeping too much, sleeping too little, difficulty staying or falling asleep, nightmares?

_____

_____

_____

Energy and ability to concentrate:

_____

_____

Intrusive memories or thoughts, avoidance behavior, flashbacks, detachment?

_____

_____

_____

Medical History

How has your physical health been?

_____

_____

_____

Primary care provider: _____

Current Medications: _____

History of seizures, illness, pain, surgery, or hospitalization:

_____

_____

_____

Issues with food/eating:

_____

_____

_____

Developmental history: low birthweight, prematurity, birth complications, in utero exposure to substances, meeting developmental milestones?

_____

_____

_____

Substance Use/ Abuse History

Please check all substances you have used:

☐ Alcohol	☐ Stimulants	☐ Inhalants	☐ Opiods	☐ Tobacco
☐ Cannabis	☐ Meth	☐ Hallucinogens	☐ Sedative/ Hypnotics	☐ Caffeine
☐ Cocaine				

Do you currently drink alcohol or use drugs (prescription or recreational)? How often and how much?

_____

_____

_____

Have you previously had issues with substance abuse? Have you ever received treatment for substance abuse? If yes, when and what was the outcome?

_____

_____

_____

_____

Gambling, risk taking, impulsive behavior (current or past):

_____

_____

Pornography, sex addictions, or any other addictions (current or past):

_____

_____

School/ Educational History

School/ level of education/ major:

_____

_____

Work History

Briefly describe past and current employment and job satisfaction:

_____

_____

_____

_____

Military

History of military service:

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date: _____**

Clinician Signature: _____ **Date: _____**

Supervising Clinician Signature: _____ **Date: _____**