



Individual Adult or Couple's Intake Form

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's counseling only)

Name: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Phone (H): _____ Phone (cell): _____

Email: _____ OK to contact via email? _____

Employer: _____ Phone (W): _____

Copy of Driver's License or other ID

Referral Source:

If referred, name of group or person that referred you to counseling: _____

Were you referred directly to The Vine Wellness 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

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How would you identify your sexual orientation?

() straight/heterosexual () lesbian/gay/homosexual () bisexual () transsexual
() asexual () other _____ () unsure/questioning () prefer not to answer

What is your spouse or significant other's occupation? _____

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, nonpsychiatric hospitalization, or surgeries:

Have you ever had an EKG? () Yes () No If yes, when: _____

Was the EKG () normal () abnormal or () unknown?

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: Y N Which Family Member?

Thyroid Disease -----	() ()	_____
Anemia -----	() ()	_____
Liver Disease -----	() ()	_____
Chronic Fatigue -----	() ()	_____
Kidney Disease -----	() ()	_____
Diabetes -----	() ()	_____
Asthma/Respiratory problems -----	() ()	_____
Stomach or Intestinal problems -----	() ()	_____
Cancer (type) -----	() ()	_____
Fibromyalgia -----	() ()	_____
Heart Disease -----	() ()	_____
Epilepsy or Seizures -----	() ()	_____
Chronic Pain -----	() ()	_____
High Cholesterol -----	() ()	_____
High blood pressure -----	() ()	_____
Head trauma -----	() ()	_____
Liver problems -----	() ()	_____

Is there any additional personal or family medical history? () Yes () No If yes, please explain:

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	Schizophrenia-----	() Yes () No
Depression-----	() Yes () No	Post-traumatic stress-----	() Yes () No
Anxiety-----	() Yes () No	Alcohol abuse-----	() Yes () No
Anger-----	() Yes () No	Other substance abuse-----	() Yes () No
Suicide-----	() 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 Psychiatric 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/misuse illegal/prescription Drugs (including Marijuana)? () Yes () No

If so, which ones and how often? _____

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? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? () Yes () No

Please describe when, where and by whom: _____

Legal History:

Have you ever been arrested? () Yes () No

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? () Yes () No

Name of congregation: _____

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? () more helpful () stressful

Mental Status Information

Are you or your significant other currently thinking about suicide or harming yourself in any way?

() Yes () No

Have you or your significant other 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 or your significant other having thoughts about harming anyone else in any way?

() Yes () No

Counseling Information

Describe the situation that brings you to seek counseling: _____

Describe what has already been done to resolve the situation: _____

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