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

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 -----------------------	( ) ( )	______________________
Other ------------------------------------	( ) ( )	______________________

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? _______
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? ___________________________
____
____
____

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