Finding Your Ase'
7215 Toccoa Cir
Union City, Ga 30291
Phone: 404-907-3895

Adult Client Intake

Demographics			
Name:		Date of Intake:	
Address:			
Email:		Phone #:	
Leave Message Okay: ☐ Yes ☐ No		Text Reminder Okay: ☐ Yes ☐ No	
Marital Status: -----	DOB:	Gender: -----	Ethnicity: -----
Emergency Contact:		Relationship to You: -----	
Email:		Phone #:	
Referral Source:			
Previous Counseling: ☐ Yes ☐ No			
If yes, provide dates:			
What did you find most helpful?			
What did you find least helpful?			

Reason for Seeking Therapy

Medical/Mental Health History	
Primary Care Provider:	Phone #:
Allergies:	Last Physical:
How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
Mental Health Diagnosis:	
Medical Diagnosis:	

Medications

List all known prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency	Prescribed By

Surgeries/Hospitalizations (Include Inpatient Treatment/Hospitalizations for Mental Health Purposes)	**Date**

Pain

Are you experiencing Pain? ☐ Yes ☐ No Location of Pain?

How Long? | Medication(s) Used for Pain?

Pain Level Today:

Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe

Women's Health

# of Pregnancies:	# of Stillbirths:	# of Miscarriages:

Have you experienced the loss of a child:

Health

Diet: How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

Purge: ☐ Y ☐ N Restrict: ☐ Y ☐ N Overeat: ☐ Y ☐ N Binge: ☐ Y ☐ N

Exercise: Do you exercise regularly? ☐ Yes ☐ No What kind of exercise?

Duration: Frequency:

Sleep: How many hours, on average do you sleep a night?

☐ Trouble Falling Asleep
☐ Trouble Staying Asleep

Physical Symptoms

☐ Headaches
☐ Muscle Tension
☐ Chest Pains
☐ Numbness
☐ Sweating
☐ Shortness of Breath
☐ Dizziness
☐ Sexual Problems
☐ Rapid Heartbeat
☐ Trembling/Shaking
☐ Joint/Muscle Pain
☐ Heart Pounding
☐ Diarrhea
☐ Fainting
☐ Fatigue
☐ Vision Changes
☐ Blackouts
☐ Chills/Hot Flashes
☐ Stomach Aches
☐ Nausea
☐ Other:

Immediate Family Members Living with Client

Name	Gender	Age	Relationship to Client	Living with Client

Family Mental Health History							
Issue/Diagnosis	Self	Father	Mother	Sister	Brother	Child	Grandparent
Depression	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
ADHD / ADD	☐	☐	☐	☐	☐	☐	☐
Trauma History	☐	☐	☐	☐	☐	☐	☐
Abusive Behavior	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Mood (Past 1-2 Weeks)	**Behavioral Symptoms (Past Month)**
☐ Calm ☐ Happy ☐ Sad ☐ Angry ☐ Anxious ☐ Frustrated ☐ Worried ☐ Hopeless ☐ Helpless ☐ Fearful ☐ Excited ☐ Depressed ☐ Other	☐ Sleep Issues ☐ Motivation ☐ Shame ☐ Guilt ☐ Concentration ☐ Racing Thoughts ☐ Loss of Sex Drive ☐ Impulsiveness ☐ Fatigue ☐ Poor Judgment ☐ Appetite Change ☐ Periods of High/Low ☐ ☐ Notes:

Risk Assessment				
Question	**Yes**	**No**	**Today**	**Recently**
Been so distressed you seriously wished to end your life?	☐	☐	☐	☐
Do you have a specific plan how you would kill yourself?	☐	☐	☐	☐
Do you have access to weapons/means of hurting yourself?	☐	☐	☐	☐
Have you made a serious suicide attempt?	☐	☐	☐	☐
Have you purposely done something to hurt yourself/self-harm?	☐	☐	☐	☐
Have you heard voices telling you to hurt yourself?	☐	☐	☐	☐
Thoughts of killing or seriously hurting someone else?	☐	☐	☐	☐
Heard voices telling you to hurt others?	☐	☐	☐	☐

Social History	**Additional Notes**
Are your parents divorced? ☐ Yes ☐ No	
Are childhood events contributing to current problems? ☐ Yes ☐ No	
Briefly describe your childhood (happy, chaotic, troubled):	
Have you experienced any abuse (physical, sexual, verbal? ☐ Yes ☐ No	
How satisfied are you with your current family life? ☐ Satisfied ☐ Unsatisfied	
How satisfied are you with the support received from family and friends? ☐ Satisfied ☐ Unsatisfied	
How satisfied are you with your quality of life? ☐ Satisfied ☐ Unsatisfied	

Do you enjoy leisure/recreational activities? ☐ Yes ☐ No	
Are you spiritual? ☐ Yes ☐ No	
Do you have any habits you'd like to change? ☐ Yes ☐ No	

Education/Work History	
Years of Education:	Degree(s):
Occupation:	Employment: -----
How many jobs have you had?	Been Fired? ☐ Yes ☐ No

Chemical Use History

Chemical Use	Yes	No	Past	Currently
Regularly use alcohol (more than 2x a week)?	☐	☐	☐	☐
Had trouble (legal/family/work) because of alcohol?	☐	☐	☐	☐
Felt you should cut down on drinking?	☐	☐	☐	☐
Felt bad or guilty about drinking?	☐	☐	☐	☐
Ever drank first thing in the morning?	☐	☐	☐	☐
Used medications not prescribed to you?	☐	☐	☐	☐
Taken more than the recommended daily dosage of meds?	☐	☐	☐	☐
Do you use marijuana?	☐	☐	☐	☐
Have you ever used a needle to get high?	☐	☐	☐	☐
Ever use more than 1 chemical at a time?	☐	☐	☐	☐
Do you avoid family activities so you can use?	☐	☐	☐	☐
Do you use it to improve your emotions, such as when you're sad or depressed?	☐	☐	☐	☐

Goals for Therapy
1. 2. 3.
Is there anything else you would like us to know?

_____ _____ _____

Client Signature Printed Name Date