Harmony Counseling Center PLLC
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Adult Intake Form

Name: _____ Date:_____

Birth date: _____/_____/_____ Age: _____ Gender _____

Address: _____

City, State: _____ Zip: _____

Home Phone: (_____) _____ May I leave a message? □Yes □ No

Cell/Other Phone: (_____)_____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Please check all of the behaviors and symptoms that you consider problematic:

□ Distractibility	□ Hyperactivity	□ Impulsivity
□ Boredom	□ Poor memory/confusion	□ Seasonal mood changes
□ Sadness/depression	□ Loss of pleasure/interest	□ Hopelessness
□ Thoughts of death	□ Self-harm behaviors	□ Crying spells
□ Loneliness	□ Low self worth	□ Guilt/shame
□ Fatigue	□ Panic attacks	□ Change in appetite
□ Lack of motivation	□ Withdrawal from people	□ Anxiety/worry
□ Suspicion/paranoia	□ Racing thoughts	□ Excessive energy
□ Mood swings	□ Sleep problems	□ Nightmares
□ Eating problems	□ Gambling problems	□ Computer addiction
□ Parenting problems	□ Sexual problems	□ Alcohol/drug use
□ Relationship problems	□ Work/school problems	□Aggression/fights
□ Social Discomfort	□ Obsessive thoughts	□ Irritability/anger
□Withdrawal from people	□ Compulsive behaviors	□ Homicidal thoughts
□ Flashbacks	□ Hearing voices	□ Visual hallucination
□ Recurring, disturbing memories		□ Other:_____

Are your problems affecting any of the following?

□ Handling everyday tasks	□ Work/School	□ Recreational activities
□ Self esteem	□ Housing	□ Sexual activity
□ Relationships	□ Legal matters	□ Health

Have you ever had thoughts, made statements, or attempted to hurt yourself? □Yes □No
If yes, please describe:_____

Have you ever had thoughts, made statements, or attempted to hurt someone else? □Yes □No
If yes, please describe:_____

Have you recently been physically hurt or threatened by someone else? □Yes □No
If yes, please describe:_____

Family History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

Please check if you have experienced any of the following types of trauma or loss:

□ Emotional abuse	□ Sexual abuse	□ Physical abuse
□ Parent substance abuse	□ Teen pregnancy	□ Neglect
□ Violence in the home	□ Crime victim	□ Parent illness
□ Financial problems	□ Lived in a foster home	□ Multiple family moves
□ Homelessness	□ Loss of a loved one	□ Placed a child for adoption

Medical History
List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____

_____

Have you ever received mental health treatment in the past? □Yes □No
If yes, explain: _____

_____

Current medications: (Include dosage and frequency): _____

_____

Medication Allergies: _____

Other Allergies: _____

Person History

To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues?
If yes, describe:_____
Do you have a religious affiliation? □Yes □No
If yes, please explain: _____

Level of education completed: □GED □ High School □Some College □Associate □Bachelors □Masters □PhD □ Other

Currently enrolled in school? □ Yes □No
If yes, where: _____

Are you currently employed? □ Yes □No
If yes, what is your occupation? _____

Briefly describe your goals for therapy: _____

_____

_____

What do you view as your major strengths and positive traits?_____

_____

_____

What are your hobbies? _____

_____

_____