CW Counseling & Consulting, LLC

Adult Intake and Personal History Form
(Self Report)

(To be completed by the patient before the initial appointment)

General Information

Full Name: _____ Date of Birth: _____ Age: ___ Gender: _____

Phone: _____ Email: _____

Address: _____

Emergency Contact (Name/Relation): _____ Phone: _____

Who referred you to our practice? _____

Demographics

Social Security Number _____ Gender Identity _____

Administrative Sex (sex assigned at birth) _____ Sexual Orientation

(enduring emotional, romantic, or sexual attraction to other people) Straight _____
Asexual_____ Bisexual_____ Lesbian or Gay_____ Unknown_____

Something else, please explain _____ Does not wish to disclose _____

Race: _____Ethnicity: (culture you identify with) _____

Marital Status: (single, divorced, married, long term relationship) _____

Military History: _____ (if yes) Branch _____ Insurance_____

EAP _____

Presenting Concerns

1) What brings you to counseling/therapy currently?

_____

2) How long have you been experiencing these difficulties?

_____

3) What do you hope to gain from therapy?

_____

Medical History

Primary Care Physician: _____ Phone: _____

Current medical conditions:

_____

Past surgeries/hospitalizations:

_____

Current medications (include dosage & prescriber):

_____

Allergies (food/medication/environment):

_____

Mental Health History

Have you ever received counseling or psychiatric treatment? □ Yes □ No

If yes, when and where? _____

_____

Past diagnoses (if any):

_____

Psychiatric hospitalizations (if any):

_____

Medications previously tried for mental health:

_____

Family & Social History

Relationship status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partnered

Children (names/ages):

_____

_____

_____

Describe your relationship with your family:

_____

Family history of mental illness, addiction, or significant medical issues:

_____

Current sources of support (family, friends, church, etc.):

_____

Financial Support

Are you receiving financial support? □ Yes □ No

If yes, please describe the source(s) of financial support:

_____

Childhood & Adolescent History

Where did you grow up?

_____

Describe your home environment growing up:

_____

Any history of abuse (physical, emotional, sexual, neglect)? □ Yes □ No

If yes, please explain:

_____

Academic history (learning difficulties, special education, ADHD, etc.):

_____

Education & Employment

Highest level of education: □ Some HS □ HS Diploma/GED □ Some College □ Bachelor's □ Graduate

Current employment status: □ Full-time □ Part-time □ Unemployed □ Student □ Retired

Occupation/Employer:

_____

Work-related stressors:

_____

Legal History

Any past or current legal issues? □ Yes □ No

If yes, please describe:

_____

Substance Use History

Alcohol: □ Yes □ No If yes, how often/how much? _____

Tobacco: □ Yes □ No If yes, how often? _____

Recreational drugs: □ Yes □ No If yes, what and how often? _____

Do you feel your use of substances is a problem? □ Yes □ No

Lifestyle & Wellness

Sleep: □ Good □ Fair □ Poor Avg. hours/night: _____

Appetite: □ Good □ Fair □ Poor Recent changes? _____

Exercise: □ Regular □ Occasional □ Rare

Hobbies or leisure activities:

_____

Spiritual/religious practices:

_____

Safety

Have you had thoughts of hurting yourself or others? □ Yes □ No

If yes, please explain:

_____

Do you have access to weapons? □ Yes □ No

Additional Information

_____

_____

Signature

Patient Signature: _____ Date: _____

For Therapist Use Only

_____

_____

_____