Freedom's Hope Counseling, LLC
Adult Intake and History

Name: _____ Date: _____

Permanent Address:_____

Phone: _____ May we leave a message at this phone: ☐Yes | ☐No

Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity: _____ Sexual Orientation: _____ Preferred Pronouns: _____

Relationship Status: _____# of Children: _____ # of Children living at home: _____

Referred by: _____ Have you had previous counseling? ☐Yes | ☐No

Are you currently receiving counseling elsewhere? ☐Yes | ☐No

Do you consider yourself religious? ☐Yes | ☐No. If Yes, what faith? _____

Do you consider yourself spiritual? _____

What is your highest education level? (select one) ☐High School/GED | ☐Some College | ☐College Degree

Are you currently employed outside the home? _____ Occupation: _____

Symptom Checklist (Check all that apply)

Anxiety: ☐Agitation | ☐Fatigue | ☐Irritability | ☐Poor Concentration | ☐Restlessness | ☐Sleep Disturbance | ☐Tension | ☐Dissociative Episodes | ☐Phobia

Depression: ☐Changes in Sleep | ☐Change in Appetite | ☐Psycho-motor Retardation | ☐Fatigue | ☐Hopelessness | ☐Change in Weight | ☐Suicidal Ideation | ☐Agitation | ☐Diminished Self-Esteem | ☐Feeling Sad/Down Most Days | ☐Excessive Guilt | ☐Not Enjoying Things You Used To

Delusions: ☐Grandiose | ☐Religious | ☐Paranoia | ☐Somatic | ☐Persecution | ☐Self Deprecating

Hallucinations: ☐Auditory | ☐Smell | ☐Touch | ☐Visual

Sense of Time: Have you ever felt like you lost time? ☐Yes | ☐No

Panic: ☐Heart Palpitations | ☐Shortness of Breath | ☐Chest Pain | ☐Nausea | ☐Dizziness | ☐Chills | ☐Hot Flashes

Mania: ☐Grandiosity | ☐Pressured Speech | ☐Increased Activity | ☐Euphoria | ☐High Risk Behaviors | ☐Decreased Sleep | ☐Racing Thoughts | ☐ Irritability | ☐Impulsivity

Impulsive Behavior: ☐Physical Aggression | ☐Attachment Issues | ☐Damage Property |
☐Maladaptive Gambling | ☐Pulling Hair Out | ☐Rageful Episodes | ☐Stealing |
☐Verbal Aggression | ☐Legal Problems | ☐Fire Setting

Abuse/Trauma: ☐Spiritual Abuse | ☐Authoritative Abuse | ☐Verbal Abuse | ☐Physical Abuse |
☐Neglect | ☐Psychological Abuse | ☐Sexual Abuse | ☐Sibling Abuse |
☐Bullying; Age(s) of abuse: _____
☐Avoiding Stimuli Associated with Trauma | ☐Hyper-arousal | ☐Flashbacks

Eating: ☐Intense Fear of Gaining Weight | ☐Distorted Body Image | ☐Binge eating |
☐Absence of Menstruation | ☐Induced Vomiting | ☐Laxative Abuse | ☐Diuretic Abuse |
☐Excessive Exercise | ☐Fasting | ☐Compulsive Eating | ☐Weight Gain | ☐Weight Loss

Learning/Attention: ☐Difficulty Writing | ☐Difficulty Reading | ☐Dyslexia |
☐Difficulty with Math | ☐Difficulty with Verbal Expression | ☐Hyperactivity |
☐Poor Attention | ☐Truancy

How would you describe your P**hysical Health** at present?

☐Poor | ☐Unsatisfactory | ☐Satisfactory | ☐Good | ☐Very Good.

Please list any persistent physical symptoms or health concerns (e.g.: chronic pain, diagnosis, etc.)

_____

Are you having any problems with your sleep? _____. If yes, please explain? _____

_____

Have you had thoughts of suicide in the past 3 months? ☐Yes | ☐No

If yes, please describe: _____

Have you had suicidal thoughts in your lifetime? ☐Yes | ☐No

If yes, please explain: _____

Have you ever had thoughts of harming other people? ☐Yes | ☐No

If yes, please explain: _____

Have you had thoughts of or do you participate in non-suicidal self-harm? (i.e.: cutting) ☐Yes | ☐No

In the past year, have you experienced life changes or stresses? ☐Yes | ☐No

If yes, please explain: _____

Please check the statements that apply to you:
☐ I do not have close friends I can talk to about personal issues.
☐ I have a good social support system.
☐ My relationship with my family is satisfactory.
☐ I have difficulty handling stress.
☐ I have difficulty expressing my emotions.
☐ I often get extremely angry.
☐ At times, I have acted in a violent manner.
☐ I am having academic or work issues.
☐ I have suffered a recent loss. Please explain: _____

_____

_____

List any significant history that is still affecting you today: _____

_____

_____

_____

Strengths and Goals:

What are some of your strengths? _____

_____

Who/What are your resources? _____

_____

What would you like to accomplish in counseling? Please list your goals: _____

_____

_____

Drug or Alcohol:

Are you taking any prescribed psychiatric medications (anti-depressants; anti-anxiety, etc.)?

If yes, please list: _____

Do you regularly use alcohol? _____ If yes, how many drinks in a 7-day period? _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? (Select One)

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What Substances do you use? _____

Do you use Marijuana? _____ If yes, THC value? _____ How many uses per day? _____

Have you ever felt that your substance use (alcohol or drug) was a problem? _____

Has anyone ever told you they were concerned about your substance use? _____

Family Information: Please include all significant family members

Name	Age	Relationship	Do they live with you?

Does your family have a history of any of the following? (Check all that apply)

☐ Depression | ☐ Anxiety | ☐ Panic Attacks| ☐ Alcohol/Drug Use | ☐ Eating Disorders | ☐ Abuse |
☐ Bipolar Disorder | ☐ Schizophrenia | ☐ Other Mental Health Concerns | ☐ Attempted/Completed Suicides |
☐ My Parents are Divorced/Separated | ☐ My Family is Not Emotionally Close

How were you disciplined as a child? _____

As a child, did you feel: ☐ Seen | ☐ Safe | ☐ Heard | ☐ Unsafe

Were there any problems with your mother's pregnancy or delivery of you? _____

Please explain, _____

Did your mother have a miscarriage prior to your birth? _____

Did you mother have post-partum depression? _____

Were there any significant illnesses in the family that could separate you from your parents or any possible disruption in child/parent attachments? _____

Emergency Contact:

Please give the name and phone number of an Emergency Contact:

Name: _____ Phone: _____

Do we have your permission to contact this person if we feel necessary? ☐ Yes | ☐ No