JANE SWEENEY • LPC-S • NCC

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Adult Intake Information Sheet

Date _____/_____/_____ Referral Source: Friend/ Physician/ School/ Internet/ Other

Name of person seeking counseling _____
Last Middle I. First

D.O.B. _____/_____/_____ Age _____ Contact Email: _____

Address _____

_____

City _____ State _____ Zip _____

Phone: Home _____ Business _____ Cell _____

Occupation _____ Employer/School _____

Marital Status: S / M / D Spouse's Name _____

D.O.B. _____/_____/_____ Age _____ Contact Email: _____

Address _____

_____

City _____ State _____ Zip _____

Phone: Home _____ Business _____ Cell _____

Persons residing in your household:

Name	Age	Relationship to person seeking counseling

Client Name: _____

Current medications:

Type	Dosage	Reason for Taking	Prescribing Physician

Current Physician _____ Phone _____

List use of Previous Counseling or Psychiatric Services (Outpatient or Inpatient)

_____

_____

_____

What brings you to counseling today?

_____

_____

_____

_____

Check if a current concern

__ Depressed Mood	__ Sleep Disturbance	__ Apathy	__ Guilt
__ Decreased Energy	__ Poor concentration	__ Appetite Disturbance	
__ Helplessness	__ Worthlessness	__ Anxiety	__ Panic Attacks
__Obsessions/Compulsions	__ Emotionally withdrawn	__ Moodiness	__ Hyperactivity
__Impaired Judgement	__ Impulsiveness	__ Grandiosity	__ Easily distracted
__ Fearful	__ Irritable	__ Anger	__ Delusions
__ Paranoia	__ Hallucinations	__ Agitated	__ Memory Loss
__ Confusion	__ Delirium	__ Binging	__ Purging
__ Weight Change	__ Somatic Complaints	__ Grief	__ Defiance
__ Physical Fighting	__ Learning Challenges	__ Marital Conflict	__ Family Conflict

Client Name: _____

Name three strengths you have or three things you like about yourself:

_____

_____

_____

_____

What do you want to accomplish in counseling?

_____

_____

_____

_____

Any other relevant information related to your current concerns:

_____

_____

_____

_____

_____

_____