BETHANY CHRISTIAN SERVICES

# INTAKE ASSESSMENT
# ADULT

**Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits.**

Client Name:_____ Date of Birth:_____

Presenting reason(s) for seeking services: _____

_____

How long has this issue persisted? _____

Under what conditions do(es) the issue(s) usually get worse and under what conditions does the issue(s) usually improved? _____

_____

Desired outcome or expectations of treatment (changes you would like to make, how we can help)? _____

_____

Please list any people, organizations or resources that may help you achieve your outcome(s):_____

_____

_____

Please list any potential barriers to achieving your desired outcome(s): _____

## Family History/Significant Relationships

| Relationship | Name(s) | Age | Living | Living with you | Quality of Relationship |
|---|---|---|---|---|---|
| | | | Yes/No | Yes/No | |
| Mother | | | | | |
| Father | | | | | |
| Spouse | | | | | |
| Children | | | | | |
| Siblings | | | | | |
| Additional | | | | | |

Please describe your family growing up (parent's marital status, birth order, parenting style): __

_____

_____

_____

Are there members of your family who have or have had mental health concerns or treatment? If yes, please explain.

_____

_____

Please identify your sexual orientation: _____

Please identify your marital status: _____

Please identify any sexual concerns: _____

_____

## Social Relationships

Briefly describe your greatest strengths: _____

_____

_____

Briefly describe your main difficulties at home:_____

_____

_____

Briefly describe your difficulties with peers: _____

_____

_____

Briefly describe your friendships:_____

_____

_____

Briefly describe your likes and dislikes (including hobbies and interests): _____

_____

_____

## Leisure/Recreational

| Activity | How often in the last 30 days? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |

## Education

Highest level of education achieved: _____

Additional Information (e.g. learning disabilities, gifted, etc.): _____

## Employment

Currently: (Please check all that apply)

| FT | PT | Temp | Laid-off | Disabled | Retired | Social Security | Student | Other (describe): |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

## Military

| Branch | Dates of Service | Combat experience | Type of Discharge |
|---|---|---|---|
| | | Yes/No | |
| | | | |
| | | | |

## Religion

How important to you are spiritual matters? ____ Not at all ____ Somewhat _____Very Much

Are you or your family affiliated with a spiritual or religious group? ____Yes ____ No If Yes, please describe: _____

_____

_____

Would you like your spiritual/religious beliefs incorporated into counseling sessions? ___ Yes ___ No If Yes, please describe: _____

## Cultural/Ethnicity

To which cultural, ethnic and/or racial group do you belong?_____

Are you experiencing any problems due to cultural/ethnic/racial issues? ____ Yes ____ No If Yes, please describe:_____

_____

Would you like cultural/ethnic practices incorporated into your counseling sessions? ____ Yes ____ No If Yes, please describe: _____

_____

## Medical History

Physician's Name: _____

Most Recent Physical Exam: _____ Results: _____

Height: _____ Weight: _____ Has there been a recent change in weight? ____Yes ____No

Most Recent Dental Exam: _____

List any past or present illnesses, operations, or conditions: _____

_____

List any current physical concerns (e.g., dizziness, headaches, stomach aches, etc.):_____

_____

_____

On average how many hours of sleep do you receive daily? _____

Do you have trouble falling asleep/staying asleep at night? _____Yes _____ No

If Yes, how long has this been a problem? _____

If Yes, please specify/explain:_____

Describe your appetite (during the past week):___ poor appetite ___ average appetite ___ large appetite

Have there been any recent changes in appetite or sleep? If Yes, please describe: _____

Please list any known allergies:_____

Please list all medications you are currently taking

| Medication | Dosage | Prescribed by |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Trauma History

Have you experienced a history or recent occurrence(s) of abuse or neglect? _____Yes _____No

If Yes, which type(s): ___Verbal ___Physical ___Sexual ___Emotional ___Neglect ___ Domestic Violence

Please describe: _____

_____

_____

Has there ever been a time when Child Protective Services has been involved with you or your family? ____Yes ____No

If Yes, please describe: _____

_____

Have you experienced any other traumas? If Yes, please describe the situation. (ex. scary medical procedures, prenatal stressors, prenatal exposure to substances, accidents, grief and loss, witnessing, experiencing or exposure to violence, natural disasters, any life threatening situation):_____

_____

_____

## Counseling/Prior Treatment History

Information about your past and present treatment

| | Yes/No | When | Where | Overall reaction to treatment |
|---|---|---|---|---|
| Counseling | | | | |
| Psychiatric treatment | | | | |
| Suicidal thoughts or attempts | | | | |
| Drug/alcohol treatment | | | | |
| Hospitalizations | | | | |
| Self-help groups * | | | | |
| Other | | | | |

*(for example, AA, Al-Anon, NA, Overeaters Anonymous, etc.)

## Substance Abuse History

Personal substance use, past and present

| | Method of use and amount | Frequency of use | Age of first use | Age of last use | Used in last 48 hours | Used in last 30 days | **Family Information** Use in immediate or extended family? |
|---|---|---|---|---|---|---|---|
| | | | | | Yes/No | Yes/No | Yes*/No |
| Alcohol | | | | | | | |
| Marijuana | | | | | | | |
| Caffeine | | | | | | | |
| Nicotine | | | | | | | |
| Other drugs | | | | | | | |

*If Yes, Please describe immediate and extended family substance use_____

_____

_____

## System Involvement

*Please check all that apply:*

☐ Family court (custody/child support) ☐ Probation ☐ Parole ☐ Relevant Criminal History ☐ Child Protective Services

☐ Probate Court (adult/minor guardianship) ☐ Medical Support for Chronic Illness

If any, please describe involvement_____

_____

<*TS>
Therapist

<*DL>
Date Reviewed with Client