Sheltered Cove Counseling Center
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Adult Client Intake Form

(This form is completely confidential)

Today's Date: ___________________

Client's Name: ______________________________ Client Date of Birth: ____________________ Age: __________

Home Address: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Email Address: ____

Referred By: ____

Primary Physician Name: ______________________________ Ph: ______________________________

Person to notify in case of an emergency: ______________________________ Ph: ______________________________
[SCCC staff will only contact this person if we believe it is a life or death emergency.]

I give permission to SCCC staff to call my emergency contact: ______________________________(Client)

Insurance Information

Primary Ins. Co: ______________________________ ID #: ____________________ Grp #: ____________________

Secondary Ins. Co: ______________________________ ID #: ____________________ Grp #: ____________________

Policy Holder name: ______________________________ Policyholder DOB: ____________________

Policy holder address: ______________________________ Policyholder SS #: ____________________

Presenting Concern(s)

Please describe your presenting concern(s): ____

Please describe any symptoms you are experiencing (panic attacks, lack of focus/concentration, etc):

Please list 2-3 goals for therapy. 1) ____

2)____

3)____

Self-Identification

Gender: ________________ Preferred Pronoun: ________________ Native Language: ____________________

Ethnicity/Cultural Identification: ____________________ Country of Birth: ____________________

Sexual Orientation: ____________________ Religious/Spiritual Affiliation: ____________________

Employment Information

Employment Status: _____ Full Time _____ Part-Time _____ Self-Employed _____ Student _____ Homemaker _____ Retired

Name of Employer: ________________________________ Number of months/years employed: _______________

Type of Work: ____________________________________ Stress Level on Scale of 1-10: ____________________

Any work concerns? ____

Any past career positions that you feel are relevant? ____

Education Information (Please list the name of school and date completed or in progress)

High School: ____________________________________ _____ In progress Date Completed: ______________________

Technical School: _______________________________ _____ In progress Date Completed: ____________________

Associate Degree: _______________________________ _____ In progress Date Completed: ____________________

Bachelor's Degree: ______________________________ _____ In progress Date Completed: ____________________

Master's Degree: ________________________________ _____ In progress Date Completed: ____________________

Doctorate: ______________________________________ _____ In progress Date Completed: ____________________

Any additional trainings/certificates? ____

If current student, what is your Status: _________ Full Time __________ Part-Time __________On-line __________ In-person

Any school concerns/stress? ____

Mental Health History

Please share any current Mental Health Diagnosis: ____

Please share any previous Mental Health Diagnosis: ____

Please describe any current or historic suicidal thoughts or attempts. _______________________________

Please describe any current or historic self-harm behaviors (i.e. cutting). ____________________________

Please describe any current or historic homicidal thoughts or attempts. ______________________________

What are your current coping mechanisms? ____

Please complete the following treatment history:

Psychiatrist: ____ Dates of Service:_______________________

Individual Therapy: ______________________________________ Dates of Service:_______________________

Couples Therapy: ____ Dates of Service: ______________________

Family Therapy: ____ Dates of Service: ______________________

Partial Hospitalization (PHP): ____________________________ Dates of Service:______________________

Intensive Family Intervention (IFI): _______________________ Dates of Service: ______________________

Inpatient Hospitalization: ________________________________ Dates of Service: ______________________

Support Group(s): ____ Dates of Service: ______________________

Other: ____ Dates of Service: ______________________

Trauma Background

The following section asks about events you may have experienced in life. Have you personally experienced or have you ever witnessed the following situations? There are many difficult experiences we can have in childhood & adulthood. We can personally experience them and/or witness others we care for have them.

Please mark "SELF" for the following events if you have experienced them.
Please mark "OTHER" if they happened to someone you cared for.
Mark "BOTH" if the experience happed to both you and someone you care for.

DURING CHILDHOOD…

________ Physical Abuse ________ Sexual Abuse/Molestation ________ Rape

________ Neglect ________ Domestic Violence ________ Combat/War

________ Chronic Illness ________ Parents Fighting ________ Community Violence

________ Medical Trauma ________ Death of a loved one ________ Accident (car/other)

________ Natural Disaster ________ Burns or Serious Injury ________Divorce

________ School Violence ________ Verbal Abuse ________ Other

In the space provided please write anything you would like us to understand about what happened.

DURING ADULTHOOD…

________ Physical Abuse ________ Sexual Abuse/Molestation ________ Rape

________ Neglect ________ Domestic Violence ________ Combat/War

________ Chronic Illness ________ Parents Fighting ________ Community Violence

________ Medical Trauma ________ Death of a loved one ________ Accident (car/other)

________ Natural Disaster ________ Burns or Serious Injury ________Divorce

________ School Violence ________ Verbal Abuse ________ Other

In the space provided please write anything you would like us to understand about what happened.

Social & Family History

Who do you currently live with? ____

Any concerns with home environment? ____

Please describe your current support system. ____

Current Marital Status: ________ Married ________ Single ________ Divorced ________ Widow / Widower

Please describe your current marriage/relationship. ____

Please describe any previous marriages/long-term relationships? ____

How many children do you have (list names and ages)? ____

Please describe any verbally or physically abusive relationships. ______________________________

How would you describe your relationship with your mother? ______________________________

How would you describe your relationship with your father? ______________________________

Parent's marital status: ________ Never Married ________ Married ________ Separated ________ Divorced ________ Other

If your parents are no longer together, how old were you when they separated? ______________

How did your parents' separation impact you? ______________________________

Please describe any other primary care givers who significantly impacted you? ______________________________

How many siblings do you have (list names and ages)? ______________________________

How would you describe your relationship with your siblings? ______________________________

Please share any FAMILY HISTORY of Mental Health Illnesses, Diagnosis, Treatment, etc.

Please share any FAMILY HISTORY of Alcohol or Drug Abuse/Addiction.

Legal History

Please share any legal history for yourself. ______________________________

Please share any family legal history that has impacted you. ______________________________

Physical/Medical History

Please share any significant **CURRENT** medical problems (i.e. diabetes), symptoms, or illnesses:
Condition #1: ______________________ When were you diagnosed? ______________________
Condition #2: ______________________ When were you diagnosed? ______________________
Condition #3: ______________________ When were you diagnosed? ______________________
Condition #4: ______________________ When were you diagnosed? ______________________
Condition #5: ______________________ When were you diagnosed? ______________________

Please share any significant **HISTORY** of medical problems (i.e. diabetes), symptoms, or illnesses:
Condition #1: ______________________ When were you diagnosed? ______________________
Condition #2: ______________________ When were you diagnosed? ______________________
Condition #3: ______________________ When were you diagnosed? ______________________
Condition #4: ______________________ When were you diagnosed? ______________________
Condition #5: ______________________ When were you diagnosed? ______________________

Please list your current medications (including over the counter meds and supplements/vitamins):

#1) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#2) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#3) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#4) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#5) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#6) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#7) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

#8) ____________ Dose ____________ Purpose ______________ Prescribing Dr. ____________

Alcohol and Other Drug History

Caffeine? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Tobacco? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Vaping? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Alcohol? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Marijuana? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Prescription Meds? _______Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Benzo? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Barbiturates? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Cocaine? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Opiates? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Inhalants? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Methadone? ________ Experiment ________ Regular Use ________ Abuse ________ Binging ________ Dependence

Age of First Use? ___________ How much/How Often? ________________________________ Last Use? ______________

Please describe and prior Alcohol and/or Other Drug Treatment or Support groups in which you have participated.

#1) Treatment _____________________ Dates: ______________________ Outcome/Was it helpful? ______________________

#2) Treatment _____________________ Dates: ______________________ Outcome/Was it helpful? ______________________

#3) Treatment _____________________ Dates: ______________________ Outcome/Was it helpful? ______________________

#4) Support Group_____________________ Dates: ______________________ Outcome/Was it helpful? ______________________

Strengths & Challenges

What are your current challenges? ____

What are your current personality strengths? ____

What are your current skills and abilities? ____

For the following list of symptoms, please select “***Current***,” “***Past***,” “***Both***,” or “***N/A***” from the dropdown box.

________________ Anxiety
________________ Depression
________________ Mood Changes
________________ Anger/Temper
________________Panic
________________Fears
________________Irritability
________________Concentration
________________Headaches
________________Loss of Memory
________________Excessive Worry
________________Feeling Manic
________________Trusting others
________________Communication
________________Drugs
________________Alcohol
________________Caffeine
________________Frequent Vomiting
________________Eating Problems
________________Severe weight gain
________________Severe weight loss
________________Blackouts
________________People in general
________________Parents

________________Children
________________Marriage/Partner
________________Friend(s)
________________Co-Worker(s)
________________Employer
________________Finances
________________Legal Problems
________________Sexual Concerns
________________Child Abuse
________________Sexual Abuse
________________Domestic Violence
________________Thoughts of hurting others
________________Hurting Self
________________Thoughts of Suicide
________________Sleeping too much
________________Sleeping too little
________________Getting to sleep
________________Waking too early
________________Nightmares
________________Head Injury
________________Nausea
________________Abdominal Distress
________________Chills/Hot Flashes

________________Dizziness
________________Diarrhea
________________Shortness of Breath
________________Chest Pain
________________Lump in the Throat
________________Sweating
________________Heart Palpitations
________________Muscle Tension
________________Pain in joints
________________Allergies
________________Often makes careless mistakes
________________Fidget frequently
________________Speak without thinking
________________Waiting your turn
________________Completing tasks
________________Paying Attention
________________Easily distracted by noises
________________Hyperactivity
________________ Fainting

Please add any additional information you believe is relevant to your presenting issue for counseling.

Thank you for taking the time to share your background with us
so that we may provide the best treatment for you!
We look forward to meeting you soon. ☺