Journey Into Wellness Counseling Services, LLC

Adult Background Information Intake Form

Today'sDate:

Full Name:_____ Name you go by:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Age:_____ SS#:_____ Marital Status:_____ Insurance Co & ID # _____
First language spoken: _____ Race/Ethnicity:_____

Phone numbers: (check preferred method of contact)

☐ Home:_____ Okay to leave message? ☐Yes ☐ No
☐ Cell:_____ Okay to leave message? ☐Yes ☐ No
☐ Work:_____ Okay to leave message? ☐Yes ☐ No
☐ Email:_____ Okay to initiate contact by email? ☐Yes ☐ No

Emergency Contact: Who should be contacted in case of emergency?

Name:_____ Relationship:_____ Phone #:_____

How were you referred? _____

Treatment Goals: Please describe what brought you into treatment and what you hope to accomplish:

Educational background:_____ Occupation/Place of Employment:_____
Shifts worked:_____ Hours per week:_____
Do you enjoy your work? ☐Yes ☐No If no, please explain: _____

Is there anything stressful about your work? ☐Yes ☐ No If yes, please explain:_____

If not employed, how long since you last worked?_____ What caused you to stop working?_____

Do you have any physical, emotional, or learning disabilities? ☐Yes ☐ No If yes, please describe:_____

Do you consider yourself to be a spiritual or religious person? ☐Yes ☐ No If yes, please describe your religion, faith, belief, and practice:

Please describe your sexual identity? _____

Family of origin information: Please describe how it was to grow up in your family:

Name Mother /Caregiver:

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain: _____

Name Father/Caregiver:

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain: _____

Significant caregiver/relative:

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain: _____

Significant caregiver or relative:

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain:_____

Sibling (full, step, or half brother/sister

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain: _____

Sibling:

Education:_____ Occupation:_____

Shifts worked:_____ Hours per week:_____

Marital/Relationship history:_____

Mental health/addiction treatment history:_____

Legal history:_____

Currently in contact? ☐Yes ☐ No If no, please explain: _____

Residence History: Please describe places lived, when, and with whom including any custody arrangements, if applicable:

Family of Creation: Please describe how you currently get along with family members:

What is your current relationship status? _____

Spouse/Partner/Significant Other name:

Education:_____ Occupation:_____
Shifts worked:_____ Hours per week:_____
Marital/Relationship history:_____
Mental health/addiction treatment history:_____
Legal history:_____
Currently in contact? ☐Yes ☐ No If no, please explain: _____
Please list any biological children including child's name, age, and other parent:

1. _____Living with you full time ☐Yes ☐ No
2. _____Living with you full time ☐Yes ☐ No
3. _____Living with you full time ☐Yes ☐ No

Please list any step-children including child's name, age, and other parent:

1. _____Living with you full time ☐Yes ☐ No
2. _____Living with you full time ☐Yes ☐ No
3. _____Living with you full time ☐Yes ☐ No

Social History

Do you have a best friend? ☐Yes ☐ No If yes, length of friendship & name:____

How many close friendships do you have?_____How many times per week do you socialize?_____

What types of social/recreational activities do you enjoy?_____

Have you previously received any type of mental health services? ☐Yes ☐ No If yes, please provide names of practitioner and dates of services:_____

Are you currently taking any prescription medications: ☐Yes ☐ No If yes, please list medications and prescriber:_____

Please list any previous hospitalizations for psychiatric or medical treatment:

Please list any significant health issues or previous accidents:

Have you ever thought about suicide? ☐Yes ☐ No

If yes, please answer the following questions:

*-When was the most recent time you thought of suicide?*_____

-Did you ever have a plan or imagine how you would do it? ☐Yes ☐ No If yes, please explain:_____

Have you ever made a suicide attempt? ☐Yes ☐ No If yes, please provide date? _____

Do you have access to any firearms? ☐ Yes ☐ No If yes, describe types_____

Have you ever engaged in self-injurious behaviors? ☐Yes ☐ No If yes, please describe:_____

Who or what are your current support systems?_____

How often do you drink alcohol? Daily Weekly Monthly Infrequently Never

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

List all substances recreational or problematic (including alcohol) that you currently use, or have used in the last year (indicate frequency and amount): _____

Have you, or anyone close to you, ever felt that you have an alcohol/drug problem? ☐Yes ☐ No

If yes, have you had any previous treatment for drug/alcohol abuse? ☐Yes ☐ No If yes, where and when were you treated? _____

Have you ever been the victim of verbal abuse ? ☐Yes ☐ No If yes, by whom:_____Was abuse reported? ☐Yes ☐ No

Have you ever been the victim of physical abuse ? ☐Yes ☐ No If yes, by whom:_____Was abuse reported? ☐Yes ☐ No

Have you ever been the victim of sexual abuse ? ☐Yes ☐ No If yes, by whom:_____Was abuse reported? ☐Yes☐

No Have you ever been the perpetrator of abuse (verbal, emotional, physical, and/or sexual)? ☐Yes ☐ No

If yes, please describe: _____

In the section below, identify if there is a family history of any of the following. If yes, please write the family member's relationship to you in the space provided (Father, Uncle, Grandmother, etc.)

Alcohol/Substance Abuse_____ Eating Disorder/Issues w food_____

Anxiety_____ Obsessive Compulsive Behaviors_____

Depression_____ Schizophrenia_____

Domestic Violence_____ Suicide (including attempts)_____

Please circle any problem that pertains to you at the present time:

- Anger
- Drug use
- Fatigue
- Finances
- Friends
- My thoughts
- Nervousness
- Self-esteem
- Sexual abuse
- Shyness
- Sleep
- Unhappiness
- Education
- Isolation
- Ambition
- Appearance
- Concentration
- Parenthood
- Relaxation
- Sexual orientation
- Energy
- Children
- Legal matters
- Under/over eating
- Depression
- Sexual problems
- Suicidal thoughts
- Self-injurious behaviors
- Nightmares
- Health problems
- Making decisions
- Physical Abuse
- Inferiority
- Career Choices
- Self control
- Alcohol use
- Headaches
- Work
- Relationships
- Divorce
- Future
- Temper
- Age
- Anxiety
- Weight
- Memory
- Fears
- Other_____

Circle anything that has happened to you in the past three years:

Death of spouse/ partner/ significant relationship
Death of family member
Major illness or injury to you
Major illness or injury to someone in your life
Relationship Change
Change in job status
Move to another state
Legal Issues
Financial Changes

Are you, or have you ever served, in any branch of the military? ☐Yes ☐ No If yes, please answer the following questions:

What branches of the military have you served:_____

Do you have combat history? ☐Yes ☐ No If yes, please describe any injuries/treatments?_____

_____

Please describe any legal issues (past or current) including arrests and driving violations:

_____

How would you rate your current physical health?
Poor Unsatisfactory Good Very Good

Please list any specific health concerns:_____

How would you rate your current sleep habits?
Poor Unsatisfactory Good Very Good

Number of hours of sleep nightly:_____ How many times per week do you exercise?_____

Please list any difficulties or changes you are experience with appetite or eating patterns:

_____

Are you currently experiencing overwhelming sadness, grief, or depression? ☐Yes ☐ No

If yes, for how long?_____ If yes, describe symptoms:_____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐Yes ☐ No

If yes, for how long?_____If yes, describe symptoms:_____

How would you rate your ability to concentrate?
Poor Unsatisfactory Good Very Good

Any recent weight loss or gain? ☐Yes ☐ No If yes, how much?_____

How would you rate your energy level?
Poor Unsatisfactory Good Very Good

Please list some of your personal strengths:

_____

Please list some of your personal challenges:

_____

Additional Information: _____

Name of Client: (please print)_____ Date of Birth:_____

Signature_____Date_____

Name and relationship of parent, guardian, or personal representative completing this form (please print):_____

_____
Signature of Parent, Guardian or personal representative Date