Individual Adult or Couple's Intake Form

Client Personal Information

Name: _____ DOB:_____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____OK to text? _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of Driver's License or other ID ☐

Significant Other Personal Information (Couple's counseling only)

Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of Driver's License or other ID ☐

Referral Source:

If referred, name of group or person that referred you to counseling: _____
Were you referred directly to The Vine Wellness for counseling? ( ) Yes ( ) No

Annual household income(optional): _____ Currently meeting your bills? ( ) Yes ( ) No

Family Information

People living in the home:
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Relationship Status:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) asexual ( ) other _____ ( ) unsure/questioning ( ) prefer not to answer
What is your spouse or significant other's occupation? _____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long was each marriage? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender:
_____
_____

Medical History

Allergies_____ Current Weight _____ Height _____

List **ALL current prescription medications** and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date

Current **over-the-counter** medications or supplements:
_____
_____
Current medical problems:
_____
_____
Past medical problems, nonpsychiatric hospitalization, or surgeries:
_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when: _____
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only:
Date of last menstrual period _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( )No
Date and place of last physical exam: _____
Current Physician: _____ Phone: _____

Personal and Family Medical History:	**Y**	**N**	**Which Family Member?**
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/Respiratory problems	( )	( )	_____
Stomach or Intestinal problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or Seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High blood pressure	( )	( )	_____
Head trauma	( )	( )	_____
Liver problems	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem?

_____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Has a relative ever been **hospitalized** for drug or alcohol use, or mental or emotional difficulties?

_____

_____

Personal Psychiatric History:

Have you had counseling in the past? ( ) Yes ( ) No

Are you currently involved in any other counseling, including lay counseling, spiritual counseling and or professional counseling? ( ) Yes ( ) No

Current or past mental health diagnoses, date of diagnosis, and by whom:

_____

_____

Intensive outpatient treatment? ( ) Yes ( ) No If so, When:_____

Where? _____

Psychiatric Hospitalizations? ( ) Yes ( ) No If so, When: _____

Where? _____

Drug and Alcohol Treatment/hospitalizations? ( ) Yes ( ) No If so, When : _____

Where? _____

Caffeine Usage:

How many caffeinated beverages do you drink a day?

Coffee _____ Sodas _____ Tea _____ Energy Drinks _____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No

How many packs per day on average? _____ How many years? _____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? _____ How many years? _____

Alcohol and/or drug use:

Do you drink alcohol? ( ) Yes ( ) No How often? _____

Type? ( ) Wine ( ) Beer ( ) Liquor ( ) Other

Are any family or friends concerned about your drinking? ( ) Yes ( ) No Explain:

_____

_____

Are you concerned about your drinking? ( ) Yes ( ) No Explain:

_____

_____

Do you use/misuse illegal/prescription Drugs (including Marijuana)? ( ) Yes ( ) No

If so, which ones and how often? _____

_____

_____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Please describe when, where and by whom:_____
_____

Legal History:

Have you ever been arrested? ( ) Yes ( ) No
Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
Name of congregation: _____
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Mental Status Information

Are you or your significant other currently thinking about suicide or harming yourself in any way?
( ) Yes ( ) No

Have you or your significant other had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ( ) Yes ( ) No

Are you or your significant other having thoughts about harming anyone else in any way?
( ) Yes ( ) No

Counseling Information

Describe the situation that brings you to seek counseling: _____
_____
_____
_____

Describe what has already been done to resolve the situation: _____
_____
_____
_____

What do you hope for in resolving the situation? What will be different? _____
_____
_____
_____
_____