Family Restoration Counseling Services PLLC
www.familyrestorationcounseling.com
Dallas 214-265-1777 Forney 469-602-5022

Confidential Client (Adult) Intake Information

Name:_____ Age:_____ Date of Birth:_____

Gender: ❑ Male ❑Female Ethnicity:_____

Street Address:_____

City/State/Zip:_____ Home Phone:_____ ❑ yes ❑no ❑N/A

Work Phone:_____ Cell Phone:_____❑yes ❑no ❑N/A

Occupation:_____ Email:_____❑yes ❑no ❑N/A

How do you prefer we contact you?: ❑ cell phone ❑home phone ❑email ❑other_____

Referred by:_____

What is your current relationship status?:
❑ single ❑divorced ❑separated ❑widowed ❑married/committed relationship

Household members: (Please include all individuals currently living in your home)

Name of household member	Age	Relationship

Briefly describe your reasons for entering into counseling at this time:
_____
_____
_____
_____
_____
_____

Have you previously received any type of mental health services (counseling, psychiatric services)?
❑ Yes ❑No
If yes, previous therapist/practitioner:_____Phone:_____

If necessary to coordinate treatment, may I contact this health care provider?
❑ Yes ❑ No ❑ N/A
Signature of client:_____Date:_____

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Family Mental Health History:
In the section below, identify if there is a family history of any of the following conditions. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, sister, etc.)

Alcohol/Substance abuse	❑ yes	❑ no	_____
Anxiety	❑ yes	❑ no	_____
Depression	❑ yes	❑ no	_____
Domestic Violence	❑ yes	❑ no	_____
Eating Disorders	❑ yes	❑ no	_____
Obesity	❑ yes	❑ no	_____
Obsessive Compulsive Behavior	❑ yes	❑ no	_____
Schizophrenia	❑ yes	❑ no	_____
Suicide Attempts	❑ yes	❑ no	_____

Medical History:
Current medical conditions/diagnosis:

Medical condition/diagnosis	Date of onset

List any significant illnesses, injuries, hospitalizations or special medical needs of client:
_____
_____
From whom or where do you receive medical care?
Clinic/doctor's name: _____ Phone:_____
If necessary to coordinate treatment, may I contact this health care provider?
❑ N/A ❑ Yes ❑ No
Signature of client:_____Date:_____

Are you currently taking any prescription medication? ❑ Yes ❑ No

Name of medication	Dose	Reason for medication

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Symptom and Issues checklist (please check all that you have experienced within the last 6 months)

❑Racing heart
❑Panic attacks
❑Restlessness
❑Shaking
❑Rapid breathing
❑Sweating
❑Trouble sleeping
❑Social isolation
❑Crying spells
❑Appetite-under/over eating
❑Lack of energy
❑Lack of enjoyment
❑Lack of interest in activities previously enjoyed
❑Lack of sexual activity
❑Poor concentration
❑Hopelessness
❑Pessimistic attitude
❑Confused thoughts
❑Inability to make decisions
❑Loss of memory
❑Moodiness
❑Poor self image
❑Guilt/Shame
❑Recent loss(es)
❑Recent crime victimization
❑Recent disaster
❑Unusual dreams/nightmares
❑Hypervigilance/Being "on guard"
❑Increased anxiety
❑Emotionally sensitive
❑Avoidance of people, places, or things
❑Daydreaming
❑Re-experiencing traumatic event in yourmind
❑Anger/Irritability
❑Health problems (self or family member)
❑Violent behavior
❑Substance abuse
❑Lack of caring/compassion for others
❑Self-harming behaviors (cutting, burning)
❑Scratching/picking cuts or skin/plucking hair
❑Unemployment/underemployment
❑Educational stress
❑Job related stress
❑Financial problems
❑Relationship problems
❑Recent or pending lifestyle change(s)

Emergency Contact Name:_____Relationship:_____

Address:_____City/State/Zip:_____

Contact Phone number:_____

I have read and understand the office policies. I have also been provided a copy of the "Inform and Consent" document to retain for my personal files.

_____ _____
Client Signature Date