Family Restoration
COUNSELING SERVICES

Confidential Adult Client Intake

Welcome to Family Restoration Counseling Services! We are honored to be a part of your journey. Please take time to fill out this form to the best of your ability. This form is confidential and will be reviewed by your therapist before your first session.

Name _____ Age _____ Date of Birth _____ Gender _____

Street Address _____ City, State, Zip _____

Email Address _____ Referred By _____

Home Phone _____ ○ Calls OK ○ Text Messages OK ○ Both OK ○ Neither OK

Cell Phone _____ ○ Calls OK ○ Text Messages OK ○ Both OK ○ Neither OK

Work Phone _____ ○ Calls OK ○ Text Messages OK ○ Both OK ○ Neither OK

Current Relationship Status:

○ Single ○ Married/Committed Relationship ○ Separated ○ Divorced ○ Widowed

Household Members: Please include all individuals currently living in your house.

Name of Household Member	Age	Relationship to Client

Please briefly describe your reasons for entering into counseling at this time:

Have you previously received any type of mental health services (counseling, psychiatric services, etc.)?

◯ Yes ◯ No

If yes, name of clinician _____ Phone _____

If necessary to coordinate treatment, may your therapist contact this clinician?

◯ Yes ◯ No

Signature of client _____ Date _____

Family Mental Health History: In the section below, identify any family history of the following conditions. If yes, please indicate the family member's relationship to you in the space provided (sister, uncle, grandmother, 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: Please list any significant illnesses, injuries, hospitalizations, or special medical needs.

From whom/where did you receive medical care for these significant events?

Hospital/Doctor's Name _____ Phone _____

If necessary to coordinate treatment, may your therapist contact this health care provider?

◯ Yes ◯ No ◯ N/A

Signature of client _____ Date _____

Current Medical Conditions/Diagnoses:

Medical Condition/Diagnosis	Date of Onset

Current Medications: Are you currently taking any prescription medication?

◯ Yes ◯ No

Name of Medication	Dosage	Reason for Medication

Symptoms & Issues Checklist: Please check all that you have experienced within the last six months:

- ☐ Racing heart
- ☐ Panic attacks
- ☐ Restlessness
- ☐ Shaking
- ☐ Rapid breathing
- ☐ Sweating
- ☐ Trouble sleeping
- ☐ Social Isolation
- ☐ Crying spells
- ☐ Over-eating
- ☐ Under-eating
- ☐ Lack of energy
- ☐ Lack of enjoyment
- ☐ Lack of interest in activities once enjoyed
- ☐ Lack of sexual interest/activity
- ☐ Poor Concentration
- ☐ Hopelessness
- ☐ Pessimistic attitude
- ☐ Confused thoughts
- ☐ Inability to make decisions
- ☐ Loss of memory
- ☐ Moodiness
- ☐ Poor self-image
- ☐ Guilt/shame
- ☐ Isolation/loneliness
- ☐ Recent loss(es)
- ☐ Recent crime victimization
- ☐ Recent disaster
- ☐ Unusual dreams/nightmares
- ☐ Hyper-vigilance (being "on guard")
- ☐ Increased anxiety
- ☐ Increased emotional sensitivity
- ☐ Avoidance of people, places, or things
- ☐ Daydreaming
- ☐ Re-experiencing traumatic events in your mind
- ☐ Anger/irritability
- ☐ Health problems (self or family member)
- ☐ Violent behavior
- ☐ Substance abuse
- ☐ Lack of caring/compassion for others
- ☐ Self-harming behaviors (cutting, burning, etc.)
- ☐ Scratching/picking cuts or skin/plucking hair
- ☐ Unemployment/underemployment
- ☐ Educational stress
- ☐ Job-related stress
- ☐ Financial problems
- ☐ Recent or pending lifestyle change(s)

Emergency Contact:

Name	Relationship	Phone Number

Street Address	City, State, Zip

I have read and completed this document to the best of my knowledge and abilities.

Client Name (Printed)	Signature	Date