Transform Within Wellness Center, LLC
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ADULT INTAKE FORM

Thank you for taking the time to complete the following forms, and any others that may be requested of you. The information you provide assists me in making a thorough and accurate assessment and to develop an individualized treatment plan to meet your needs.

Today's Date: ____/____/____ Client's Date of Birth: ____/____/____

Client's Name: ___________________________________ Therapist's Name: ________________
Phone number: (H) _________________ (W) ________________ (C) ________________
Which number would you prefer I call and best times: ______________________________
Any restrictions for leaving messages at the above numbers? _______________________
Email address: (I do not store email addresses in my email so I appreciate if you share your email address here so that I can contact you by email if needed.) ________________________________

- **I ask that the only information shared through email is regarding scheduling. Anything else please communicate by calling me.**

Text Messages: Please indicate here if you do **not** want to receive text messages. I ask that the only information communicated through text messages is again about scheduling. ______

Who referred you to this counselor for services? __________________________________
May I have permission to thank this person/organization for the referral? ☐Yes ☐No
If yes, please leave a number they can be contacted. ________________________

1. Your racial or ethnic origin (check one):
☐Native American ☐Black/African American ☐Caucasian/White
☐Asian/Pacific Islander ☐Hispanic/Latino ☐Multi-ethnic ☐Other

2. Spiritual Affiliation: ________________________________
Would you consider your faith important in our work together? __________

3. The highest level of education that you have completed (check one):
☐No formal education ☐Some grade school ☐Complete grade school
☐Some high school ☐Completed high school ☐Some college
☐Completed college ☐Some graduate work ☐A graduate degree +

4. Your present employment status:
☐Employed full-time ☐Employed part-time ☐Unemployed
☐Full-time homemaker ☐Retired ☐Full-time undergraduate
☐Part-time student ☐Full-time graduate student ☐Other: _________________

5. Your present annual family income (check one):
☐$0-7,999 ☐$8,000-13,999 ☐$14,000-20,999 ☐$21,000-33,999
☐$34,000-42,999 ☐$43,000-51,999 ☐$52,000 and above

6. You are currently (check one):
__Single __Engaged __ Cohabitating __Married __Separated Divorced__
__Remarried

7. Is this your first marriage?
__Yes. How long have you been married? ___________________
__ No. How many times have you been married? ______________
Number of years married to present spouse: ____________
Have you and your spouse ever been separated?
__Yes. When? ___________________ How long?__________________

8. Current Household Composition and Immediate Family. (*Please include people in your current household as well as spouse/partner and children*).

Name	Age	Relation to you	Occupation/School	In Home?

9. Family of Origin Information (*Please list members of your birth family and people in your home while you were growing up).*

Name/Relation	Age	Occupation	Living	If deceased, cause?	When?

10. Did you ever experience or witness any physical, emotional, or sexual abuse in your past or current relationships? (***If yes, please discuss with this therapist.)_________*** ________________
____

11. Are your parents still together? ___________
If they divorced, or separated, what was your approximate age at that time? ____

Presenting Problems

12. What is/are the reason(s) you are seeking therapy today? _______________________
____

13. Did a specific event lead to this request for service? If yes, please describe the incident.
____

14. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life when this therapy is helpful to you? __________________________
____

15. How will you know when you have reached your goal?
____
____

16. What do you consider your greatest strengths and your biggest struggles?
____
____
____

17. Have you ever seen a counselor or therapist (e.g., psychiatrist, psychologist, social worker, clergy, family therapist) for emotional difficulties? ☐Yes ☐No
If yes, please list dates of counseling and reason(s) for contact, beginning with the most recent one.
____
____
____

18. Please describe your past therapy experience.
____
____
____

19. Are you currently involved with any other community-based support groups (e.g., 12-step groups, social support groups) or seeing someone else regarding mental health concerns?
☐Yes What/Whom? ____
☐No

20. Have you ever attempted to harm yourself through cutting or other self-injurious behavior?
If yes, how many times and how recently? ____________________________________

21. Do you currently have any suicidal thought, plan, or intent (***If yes, please discuss with therapist)***? ____

22. Are you currently taking any medications? (***If yes, please list)***
Medication ____________________ Dosage __________________
Medication ____________________ Dosage __________________
Medication ____________________ Dosage __________________

Clinic/Doctor's Name: ____
Phone Number: ____
Address: ____

23. List any significant health problems, past or present, including surgeries or illness.
____

24. Date of your last physical exam. ______/______/_______

25. Have you or anyone else been concerned about your chemical use? (***If yes, please describe**.)*
____

26. Was use of chemicals a problem in your family growing up, or is it a problem in your current relationships? (***If yes, please describe**.)*
____

27. Please check yes or no to the following:

	Yes	No
1. Have you ever felt you should cut down on your drinking/chemical use?		
2. Have people annoyed you by criticizing your drinking/chemical use?		
3. Have you ever felt bad or guilty about your drinking/chemical use?		
4. Have you ever had a drink/used first thing in the morning to steady your nerves or get rid of a hangover?		

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28. Please describe your use of the following substances:

	Daily	Weekly	Occasionally	Not at all
Caffeine				
Tobacco				
Alcohol				
Prescription Drugs				
Street Drugs				
Over the Counter Medication				

Thank you very much for taking the time to share this personal information. It will greatly help me in your assessment and treatment process. If there is anything else you would like to add, please feel free to include on the back of this sheet or discuss during our meeting.