Adult Intake Form

Welcome to **Fairbanks Biofeedback & Counseling**. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to print and complete this form. The information helps me to understand your situation and find potential solutions to get you back on track. Please note that this information is confidential and will not be released to anyone without your written permission.

Sources of Stress

Please list the reasons that bring you here today. This may include problems, issues, significant losses or changes that are causing you stress.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Adult Strength Scale

Please circle the areas below that apply to you.

Home

1. I feel part of the family	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my spouse	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am physically healthy	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I have an enjoyable social life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I feel accepted by others	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am a good father/mother	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I participate in decision making	Seldom	Just a little	Pretty Much	Very Much	N/A

Work

1. I get to work on time	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am respected by my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am respected by my supervisor(s)	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I enjoy working	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I have realistic career goals	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I am a hard worker	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I balance home and work	Seldom	Just a little	Pretty Much	Very Much	N/A

Emotional

1. I cope well with frustration	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I cope well with disappointment	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I use anger constructively	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am satisfied with life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I accept responsibilities for my mistakes	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I drink (alcohol) responsibly	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I can take constructive criticism	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I think before I act	Seldom	Just a little	Pretty Much	Very Much	N/A
9. I have good self-esteem	Seldom	Just a little	Pretty Much	Very Much	N/A

Social

1. I make and keep friends	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I'm open to new ideas	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am considerate of others	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I stand up for myself	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I show leadership	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I am comfortable around others	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I get along with others	Seldom	Just a little	Pretty Much	Very Much	N/A

Attention

1. I cope with external distraction	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I maintain attention to tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I follow through on tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A

Problems That You Are Struggling With

Please check ( ) those that apply to you.

( ) Depression
( ) Anxiety or panic attacks
( ) Suicidal thoughts
( ) Suicidal actions
( ) Brother/sister problem
( ) Violence in family—actual or threatened
( ) Sexual problems
( ) Unemployed
( ) Legal problems
( ) Compulsive gambling
( ) Death of a loved one
( ) Attention and/or concentration issues
( ) Stress-related issues
( ) Parent-child conflict (self)
( ) Parent-child conflict (spouse)
( ) Marital/relationship problems
( ) Remarried family problems
( ) Anger/temper problems
( ) Job/school problem
( ) Sexual abuse—adult/child
( ) Low self-esteem
( ) Eating problems
( ) Major losses/difficult changes
( ) Communication problems
( ) Performance anxiety
( ) Alcohol/drugs

Do you use alcohol and/or drugs? *(circle)* Yes No

Specify: (*include history, current use, as well as type, amount, and frequency)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Problems With Coping

Please check ( ) the problems that apply to you.

( ) Sleep problems
( ) Difficulty falling asleep
( ) Waking in the middle of the night
( ) Waking too early
( ) Sleeping to much
( ) Nightmares
( ) Moody or crying more than usual
( ) Difficulties concentrating
( ) Problems remembering things
( ) Withdrawing from others
( ) Repeated actions I can't stop
( ) Can't stop washing hands/body, counting
( ) Checking things
( ) People picking on me
( ) Self-harm
( ) I cut myself
( ) I burn myself
( ) I hit myself

( ) Change in appetite
( ) Gaining weight (specify _____)
( ) Losing weight (specify _____)
( ) Not hungry or not eating
( ) Throwing up after eating
( ) Feeling sick to my stomach
( ) Constipation or diarrhea
( ) Feeling guilty, worthless, or hopeless
( ) Fatigue/low energy
( ) Hyper/too much energy
( ) Loss of interest in things
( ) Disturbing thoughts I can't stop
( ) Low self esteem
( ) Hallucinations
( ) I hear things that are not real
( ) I see things that are not real
( ) I smell things that are not real
( ) I feel things that are not real

Other: *(specify)* _____

_____

_____

_____

_____

_____

List previous suicide attempts: *(if none, write "none")*

When **Method**

_____

_____

_____

_____

List inpatient psychiatric and/or drug-alcohol rehab hospitalizations: (*if none, write "none")*

Dates (from - to) **Reason**

_____

_____

_____

_____

Previous or current counseling: *(if none, write "none")*

Therapist or agency **Dates (from - to)** **Focus of sessions**

_____

_____

_____

_____

What was helpful and/or not helpful about your previous/current counseling experience? _____

_____

_____

_____

_____

_____

_____

List medications you regularly take—please include prescriptions, over-the-counter drugs, and herbal remedies: *(if none, write "none")*

Name of Medication **Dosage** **Frequency**

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? *(circle)* Yes No

If yes, specify: _____

Are you currently on probation? *(circle)* Yes No

Have you ever been in jail or prison? *(circle)* Yes No

If yes, specify: _____

_____

Family Information

Please list the people that you currently live with:

Name	**Relationship**	**Age**

Do you have other children not living with you? *(circle)* Yes No

Specify: *(list names and ages)* _____

_____

Does your family have any psychiatric or substance abuse history? *(circle)* Yes No

Specify: _____

_____

_____

_____

Does your family have a history of major health problems? *(circle)* Yes No

Specify: _____

_____

_____

_____

What is your relationship like with your parents? _____

_____

_____

_____

_____

List family, friends, support groups and community groups that are helpful to you:

_____

_____

_____

_____

Have you ever been in the military? *(circle)* Yes No

Specify: _____

_____

_____

_____

_____

What is the highest level of education you've completed? _____

Are there any guns or weapons in your house? *(circle)* Yes No

Specify: _____

_____

_____

_____

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation.

0%-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Your Goals

Goals are very important in counseling. They provide us with focus and direction that will help us to help you. List the goal(s) that you hope to achieve in counseling. Please be as specific as possible.

1._____

_____

2._____

_____

3._____

_____

How many sessions do you think you will need to get back on track?

Please check ( ) the answer which best describes your expectations.

( ) 1-3 sessions ( ) 4-6 sessions ( ) 7-9 sessions ( ) 10-12 sessions

( ) 13-15 sessions ( ) Other: *(specify)* _____

Feedback

What do you think of this form?

Please check ( ) the answer(s) that apply.

( ) It shouldn't be used. ( ) It was okay. ( ) The questions were too personal.

( ) I didn't really understand the questions. ( ) It's a good way to gather needed information.

How could this form be improved? _____

_____

_____

_____

Signature: _____ **Date:** _____