Peace of Mind

Counseling and Educational Services

ADULT INTAKE FORM

PRIMARY CLIENT INFORMATION

Full Name:

Address:

City State & Zip:

Birthdate & SSN:

Home Phone: Cell Phone:

Email Address:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorce ☐Domestic Partnership

***Your email address will only be used to send appointment reminders.**

EMERGENCY INFORMATION

In case of emergency, contact;

Full Name:

Relationship: Phone:

Current Physician: Phone:

Current Medications:

INSURANCE INFORMATION

Member Employer:

Primary Insurance: Phone:

Contract/ID #: Group/Acct#:

Effective Date: Expiration Date:

Client: Client Date of Birth:

Relationship to Member: ☐Self ☐Spouse ☐Child

EAP Infirmation: EAP Company Number of sessions:

Signature of Member: Signature of Client**:**

MENTAL HEALTH HISTORY

Check symptoms that you have experiences over the past month?

Ineffective communication	Difficulty problem solving	Abusive relationship
Inability to handle stress	Self-Harm	Dependency on others
Substance abuse	Anger management issues	Low self-esteem
Sense of lack of control	Identity or sexuality concerns	
Difficulty meeting role expectations		
Manipulation of others to fulfill your own desires		

Difficulty falling/staying asleep	Difficulty staying asleep	Not feeling rested

Withdrawing from others	Depressed Mood	Feeling Numb
Rapid mood changes	Irritability	Outbursts of anger
Frequent feelings of guilt	Panic Attacks	Anxiety
Avoiding people and places		
Fear of certain objects or situations (i.e. flying, heights, bugs) Describe		
Difficulty leaving your home		

Worthlessness	Hopelessness	Sadness
Helplessness	Fear	Feeling or acting

Unusual sweating	Increased energy	Decreased energy
Tremor	Dizziness	Frequent worry
Racing thoughts	Intrusive memories	Muscle tension
Flashbacks	Nightmares	Difficulty concentrating
Easily startled	Difficulty catching your breath	
Thoughts of harming self	Thoughts of harming or killing someone else	

What are your reasons for seeking therapy?