Inner Peace
Coaching & Counseling

ADULT COUNSELING INTAKE

General Personal Information:

Print Name: _____ DOB: _____ Date of Appt.:_____
□ Yes □ No I received the Inner Peace Coaching & Counseling "Informed Consent" form and was given the opportunity to ask questions.
Marital Status: □ Single □ Married □ Other _____
Persons living in my home: _____
Children (first name/age): _____
Employment Status: _____What type of work do you do? _____
Is your condition related to: □ Employment? □ Auto Accident? In what State? _____ □ Other Accident_____
Religious affiliation: _____ Military History: _____
Education: Highest grade completed _____ Degree _____ Other _____

Your Counseling History, Needs & Goals:

Please tell me, briefly, about your reasons for seeking counseling:
_____
_____
_____
_____
Who referred you here? _____
Is counseling mandated? □ Yes □ No
Please tell me about your previous counseling experience(s):

Provider	Where	When	How long	Useful?
_____	_____	_____	_____	□ Yes □ No
_____	_____	_____	_____	□ Yes □ No

Clinician's Notes: (Client, please do not complete this section.)

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Please check any concerns you are having:

□ Loss of loved one through death	□ Separation from loved one	□ Divorce
□ Change of jobs	□ Loss of employment	□ Lifecycle transition
□ Marriage	□ Employment conflicts	□ Stress
□ Spouse/Significant other conflict	□ Family conflict	□ Parenting issues
□ Miscarriage/stillbirth	□ Pregnancy	□ Fertility issues
□ Behavior of adult children	□ Health problems	□ Custody issues
□ Health problems in family	□ Victim of physical abuse	□ Financial problems
□ Substance abuse	□ Gambling	□ Eating disorder
□ Excessive computer use	□ Weight management	□ Rape
□ Pornographic interest	□ Violent/abusive behavior	□ School problems
□ Problems getting along w/people	□ Housing problems	□ Retirement

Are you currently having suicidal thoughts? □ Yes □ No If yes, please describe: _____
_____
_____

Have you ever made a suicide attempt? □ Yes □ No If yes, when and how? _____
_____
_____

Has anyone related to you made a suicide attempt? □ Yes □ No If yes, please tell me about it: _____
_____
_____

Are you currently having homicidal thoughts? □ Yes □ No If yes, please describe: _____
_____
_____

Have you, or anyone related to you, ever attempted a homicide? □ Yes □ No If yes, please describe:
_____
_____

Do you worry about your safety in your current living situation? □ Yes □ No If yes, please explain:
_____
_____

Have you ever struck or threatened people or animals or broken things in your home? □ Yes □ No
If yes, please describe: _____
_____

Clinician's Notes: (Client, please do not complete this section.)

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Please check any words that apply to you:

□ Worthless	□ Useless	□ A "nobody"	□ Inadequate	□ "Life is empty
□ Stupid	□ Repulsive	□ Naive	□ Incompetent	□ Unattractive
□ Guilty	□ Evil	□ Hostile	□ Full of hate	□ Anxious/Worry
□ Agitated	□ Morally wrong	□ Cowardly	□ Unassertive	□ Horrible thoughts
□ Panicky	□ Aggressive	□ Ugly	□ Deformed	□ "Can't do anything right"

Please check any symptoms that apply to you:

□ Headaches	□ Dizziness	□ Fainting spells	□ Heart palpitations
□ Stomach trouble	□ Anxiety	□ Fatigue	□ Bowel disturbances
□ No appetite	□ Anger	□ Insomnia	□ Nightmares
□ Panicky feeling	□ Drink a lot	□ Feel tense	□ Conflict with others
□ Tremors	□ Use drugs	□ Allergies	□ Suicidal ideas
□ Depressed	□ Unable to relax	□ Sexual problems	□ Shy with people
□ Don't like vacations	□ Overambitious	□ Feel driven	□ Can't make friends
and weekends	□ Inferiority feelings	□ Can't keep a job	□ Memory problems
□ Lonely	□ Financial problems	□ Excessive sweating	□ Can't concentrate
□ Can't make decisions	□ Home conditions bad	□ Often use aspirin or painkillers	
□ Unable to have a good time		□ Other _____	

What are your strengths?

□ Bright	□ Insightful	□ Motivated	□ Active
□ Have self-control	□ Have friends	□ Can calm myself	□ Mostly healthy
□ Can ask for help	□ Keep my boundaries	□ Have moral ethics	□ Can solve problems
□ Can forgive	□ Can express feelings	□ Have enough money to meet my needs	
□ Resourceful	□ Sense of humor	□ Compassionate	□ Patient
□ Good listener	□ Stable employment	□ Satisfied with employment	
□ Willing to learn new attitudes and behaviors		□ Can accept love & care from others	

□ Other strengths _____

Your Social History

How often have you been married and how long? _____

_____

Clinician's Notes: (Client, please do not complete this section.)

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Is there anything unusual about your childhood that I should know about? _____
_____
_____
Have you experienced any significant traumatic events? _____
_____
Have you experienced any significant losses? _____
_____
Please list your brothers and sisters and their ages: _____
_____
Please describe any significant legal history (i.e., arrest, bankruptcy): _____
_____
Is there anything else significant that you want me to know? _____
_____

Clinician's Notes: (Client, please do not complete this section.)

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Medical History

Family Physician: _____
Date of last physical examination? _____
Please check any illnesses you currently have or have had in the past:

□ Diabetes	□ High Blood Pressure	□ Lung Disease	□ Venereal Disease
□ Asthma	□ Low Blood Pressure	□ Cancer (Syphilis/Gonorrhea)	
□ Arthritis	□ Heart Disease	□ Kidney Disease	□ Head Injuries
□ Pneumonia	□ Thyroid Disease	□ Hepatitis	□ Injuries
□ Anemia	□ Tuberculosis	□ Cirrhosis	□ Muscle Disorder
□ Ulcer	□ Colitis	□ Bond Disorder	□ Obesity
□ Seizures	□ Nerve Disorder	□ Anorexia	□ AIDS/HIV

□ Alcohol/Drug Problems □ Allergies _____
□ Other (Please describe) _____
_____
Is there a history of depression, mental illness, or alcohol/drug problems in your family of origin? If yes, please explain: _____

Clinician's Notes: (Client, please do not complete this section.)

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Please tell me about your past hospitalizations (include psychiatric or substance abuse treatment):

Date	Reason	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking any medications now? If yes, please list and include over-the-counter medications you take routinely:

Medication	Dosage	How Often?	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take supplements or herbs routinely? If yes, please list:

Supplement/Herb	Dosage	How Often?	Reason for Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any side effects/allergic reactions from taking medication? If yes, please explain: _____

_____

Please tell me about how much caffeine you consume:
Estimated daily consumption of coffee or tea: _____ cups/day
Estimated daily consumption of soda or cola: _____ ounces/day

Clinician's Notes: (Client, please do not complete this section.)

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Psychiatric/Substance Use Information:

Please tell me about your family's history of alcoholism, substance abuse and psychiatric problems. Indicate which, if any, family members you either suspect have had difficulties in these areas and/or have received treatment for these problems.

NP = No Problem UP = Untreated Problem TP = Treated Problem UK = Unknown

Relationship	**Alcoholism/Substance Abuse**	**Psychiatric Problems**
Grandparents	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Mother	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Father	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Brother/Sister	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Children	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Spouse/Sig. Other	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK
Other (Specify) _____	□ NP □ UP □ TP □ UK	□ NP □ UP □ TP □ UK

Do you have a history of IV drug use? □ Yes □ No
Have you ever felt you needed to cut down on your drinking? □ Yes □ No

Have people annoyed you by criticizing your drinking? □ Yes □ No
Have you ever felt guilty about drinking? □ Yes □ No
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? □ Yes □ No
Do you drink socially? □ Yes □ No If yes, how often? _____ How much? _____
How old were you when you took your first drink? _____
Have you ever attended A.A., Al-Anon, or N.A.? □ Yes □ No
Have you ever had a D.U.I.? □ Yes □ No If yes, how many? _____
Have you ever been arrested for a drinking or drug-related offense of any kind? □ Yes □ No If yes, please explain:
_____

Substance Category	Common Names (Circle all that apply)	Never Used	Did Use But Quit	Use Less Than 1x Per Month	Use 1-4x Per Month	Use 1-4x Per Week	Use 1 Or More Per Day	Age First Used
Tobacco	Cigarettes Snuff Cigars Chewing Tobacco							
Alcohol	Beer Wine Hard Liquor							
Marijuana	Marijuana Pot Hashish Grass Hash Oil Reefer							
Cocaine	Coke Snow Crack Rock Blow Nose Candy							
Other Stimulants	Amphetamines Speed Crank Dexedrine Diet Pills							
Depressants	Barbiturates Downers Tranquilizers 'Ludes Sleeping Pills							
Inhalants	Glue Gasoline Aerosols Rush Poppers Nitrous Whippets Amyl Nitrate							
Narcotics	Heroine Morphine Methadone Darvocet Codeine Percodan Oxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch							
Hallucinogens	LSD Peyote Acid Mescaline PCP Mushrooms Ecstasy							
Over-the-Counter Drugs	Cold Pills Diet Pills Cough Syrups No Doz Mini Thins Compose Sleep Aids Yellow Jackets							

Clinician's Notes (Clients, please do not complete this section.)

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Dear Client,
Thank you for completing this form. Please bring it with you to your initial appointment.