Cypress Counseling Center

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Counselor

Adult Evaluation Intake Form

1. Patient Contact Information

Patient Name_____ Preferred Name _____

Address: _____

Best contact phone number: _____ Email Address: _____

2. Date of Birth _____

Family mental health/addiction/alcoholism history: _____

_____

Is there anyone in your family that you do not have contact with? If so, with whom?_____

_____

Who was in your family while you were growing up?_____

_____

_____

Spiritual/Religious

What is your Spiritual background? _____

How important to you are spiritual matters? ___Not ___Little ___Moderate ___Much

Are you affiliated with a spiritual or religious group? ___No ___Yes (describe) _____

_____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___No ___Yes (describe) __

_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercise, diet/health, hunting, fishing, bowling, traveling, etc..)

Activity How often now? How often in the past?

_____

_____

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Medical/Physical health

Check all that apply:

AIDS	Constipation	Hepatitis	Sore throat	Chicken pox	High blood pressure
Scarlet fever	Abdominal pain	Dental problems	Kidney problems	Sinusitis	Abortion #
Allergies	Diarrhea	Stroke	Anemia	Dizziness	Mumps
Sexual Problems	Appendicitis	Menstrual pain	Tonsillitis	Asthma	Ear infection
Toothache	Neurological Disorders	Bronchitis	Eating problems	Nausea	Fainting
Thyroid Problems	Bed wetting	Nose bleeds	Vision problems	Cancer	Fatigue
Pneumonia	Vomiting	Chest pain	Frequent Urination	Colds/coughs	Rheumatic fever
Whooping cough	Chronic pain	Headaches/ migraines	STDs	Hearing problems	Sleeping disorders

Other: _____

_____

Please check if there have been any recent changes in the following:

___Sleep patterns ___Eating problems ___Behavior ___Energy level ___Physical activity level

___General disposition ___Weight ___Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

_____

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Counseling/Prior treatment history

Have family or significant other had counseling or treatment? ___No ___Yes (describe) _____

_____

_____

	No	Yes	When	Where/What	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/Alcohol Use Past					
Drug/Alcohol Use Current					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help groups					

Please circle behaviors and symptoms that occur to you more often than you would like to take place: (current behaviors and symptoms)

Aggression Dizziness Irritability Speech Problems Alcohol dependence Drug dependence

Judgment errors Suicidal thoughts Anger Eating disorders Memory impairment

Thoughts disorganized Antisocial behavioral Elevated mood Mood shifts

Trembling Anxiety FatiguePanic attacks Withdrawing Avoiding People

Gambling Phobias/Fears Worrying Hallucinations Recurring thoughts Cyber addiction

Depression Sexual difficulties Hopelessness Disorientation Sick often Distractibility

Impulsivity Sleeping problems

Any current suicidal thoughts/plan? ___No ___Yes (explain plan) _____