Catholic Family Services

Intake Forms – Adult

PRESENTING PROBLEM

Please tell us why you are seeking services at this time._____

_____

_____

What do you hope to accomplish from the services you receive?_____

_____

SYMPTOM CHECKLIST – Please check all that apply.

Past	Present		Past	Present	
		Addictions			Hopelessness
		Aggressive behavior			Hyperactivity
		Anger			Impulsivity
		Anxiety/worry			Isolation
		Appetite changes			Lack of motivation
		Breaking the law			Learning problems
		Crying spells			Loss/death of a significant person
		Decreased energy			Marital/relationship problems
		Depression			Mood swings
		Developmental disabilities			Physical complaints
		Difficulty concentrating			School problems
		Disobedience			Self-mutilation
		Drugs/alcohol			Sexual problems
		Eating disorders			Sleep changes
		Fears			Speech/language problems
		Fighting			Stress
		Fire setting			Suicidal thoughts
		Hallucinations			Temper tantrums
		Health problems			Wets bed
		Homicidal thoughts			Other:

FAMILY AND SOCIAL INFORMATION

Please list family members and others who are living at your address.

Name	Relationship	Age

Please list any of your children who are not living at your address.

Name	Relationship	Age

Date of Present Marriage_____ Date of Separation, if applicable_____
Date of Previous Marriage_____Date of Separation/Divorce_____
Date of Previous Marriage_____Date of Separation/Divorce_____

Please list your family members, including biological and step family members.

Family Member	Name	Age	Marital Status	If deceased, date and cause
Parent				
Parent				
Parent				
Parent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

How would describe your relationship with your mother?_____

How would you describe your relationship with your father?_____

Have you or any family members been physically, emotionally, or sexually abused? If yes, please describe._____

_____

_____

Have you ever been a perpetrator of abuse? If yes, please describe._____

_____

Is spirituality/religion a part of your life? If yes, please describe._____

_____

Who are your main social supports?_____

EDUCATION INFORMATION

Were you ever diagnosed with a learning or conduct disorder while in school? If yes, please describe._____

_____

Were you ever bullied in school? If yes, please describe._____

EMPLOYMENT INFORMATION

How long have you been employed in your present job?_____Length of longest employment_____

What types of jobs have you previously held?_____

Are you under work/financial stress? If yes, please describe._____

LEGAL INFORMATION

Have you ever been arrested? If yes, please describe._____

_____

Are you currently on probation or parole? If yes, please describe._____

_____

Are you currently involved in any legal actions, such as divorce, bankruptcy, or lawsuit? If yes, please describe._____

_____

Have you ever received a DWI or DUI? If yes, please describe._____

SUBSTANCE ABUSE INFORMATION

Do you smoke or use tobacco? If yes, how much and how often?_____

How many times a week do you drink alcohol?_____How many drinks do you usually consume during each occurrence?_____

Have you ever felt the need to cut down on your drinking? _____Yes _____No
Have you ever become annoyed at criticism about your drinking _____Yes _____No
Do you ever feel guilty about your drinking? _____Yes _____No
Do you ever need a drink in the morning to get going? _____Yes _____No

Do you or any family members have a history of alcohol and/or drug abuse/dependency? If yes, please describe._____

_____

MEDICAL INFORMATION

Primary Care Doctor_____Phone #_____Last Exam Date_____

Please list any current and past impairments, illnesses, surgeries, and hospitalizations._____

_____

_____

Allergies_____

How frequently do you exercise?_____

Current Medications

Name of Medication	Dosage	Frequency	Taken As Prescribed?	Date Started	Prescribing Physician	List Any Side-Effects

Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

Individual Receiving Treatment	Type of Treatment (i.e., outpatient, inpatient, residential, chemical dependency, etc.)	Service Provider	Dates

STRENGTHS

Please list some of your strengths and positive qualities._____

_____

What hobbies and interests do you enjoy?_____

_____

Is there anything else you would like us to know?_____

_____