Richmont Trauma Center

Adult Intake Form **CONFIDENTIAL**

The following form will become a part of your confidential record. It will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:_____Date of Birth_____Age_____Sex_____

Present Address_____
Number *Street*

_____
City *County* *State* *Zip Code*

Phone: _____Cell Phone:_____

Email Address: _____ Ethnicity_____ Years of Education____

Referred by: _____ May we send a thank you? _____

Marital Status: Single_____ Married_____(# of Years _____) Divorced_____ Separated_____

Presently Living With: Parents ____ Spouse ____ Roommate_____ Alone____ Other_____

Occupation_____Total Hours/Week_____

Employed by_____Phone_____

Family member to notify in case of emergency: Name:_____

Address:_____ Phone:_____

Religious Affiliation_____Church_____

Are you a member? Yes_____ No_____ Active_____ Inactive____

Please describe your spiritual history (if any):

_____

_____

_____

Have you ever experienced any severe psychological trauma? _____ If yes, please describe below:

_____

_____

_____

Have you ever experienced any neurological trauma? _____ If yes, please describe below:

_____

_____

FAMILY OF ORIGIN

Relationship	Name	Age	Education	Occupation
Father				
Mother				
Brother(s)				
Sister(s)				

Please describe your relationship with family of origin:

Parents:

Siblings:

CURRENT FAMILY RELATIONSHIPS

Relationship	Name	Age	Education	Occupation
Spouse				
Children				

Please describe your current family relationships:

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Nervousness

_____ Financial problems

_____ Marital problems

_____ Physical problems

_____ Problems with social relationships

_____ Problems with children

_____ Problems with parents

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Use of alcohol

_____ Use of alcohol by family member

_____ Use of other drugs

_____ Work

_____Worry

_____ Other (specify) _____

_____

Do you use alcohol? _____ If so, how much per day/week? _____

_____

Describe any physical problems you have that require medication or physical care:

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult with your primary care physician? _____

Are you currently taking any prescription medications? Yes _____ No _____ If yes, please list by name and dosage: _____

_____

Previous Counseling Yes_____ No_____ If yes, when?_____

With whom? Name _____Address:_____

_____

Briefly explain the problem which prompted you to seek counseling:

_____

_____

_____

_____

Why are you seeking counseling *now*?

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped? _____

_____

_____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

_____

_____

Are there other people who play a major role in causing your problems or in helping you cope with your problems? Yes _____ No _____

Explain briefly: _____

_____

_____

Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

_____

_____

_____

_____

I have read the attached Information sheet and voluntarily request counseling services at Richmont Graduate University in accord with terms described on the information sheet.

Signature _____ Date _____

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Parent/Guardian _____ Date _____

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION

If you indicated that we may send a thank you, please provide a referral name and any contact information you have below:

_____

_____

With your permission, a survey may be mailed to you upon the completion of your counseling experience at the center. Please indicate your preference in the appropriate box below.

You may send the survey ☐ Do not send the survey ☐

PLEASE COMPLETE THE FOLLOWING SENTENCES:

1. **The most important thing to me is**
2. **I worry about**
3. **What I do best is**
4. **I have sometimes felt guilty about**
5. **What makes me angry is**
6. **My biggest mistakes were**
7. **My job**
8. **What makes me nervous is**
9. **My personality would be better if**
10. **I often felt that mother**
11. **Jesus Christ is**
12. **My temper**
13. **My childhood**
14. **Prayer is**
15. **My biggest disappointment**
16. **To me, sex is**
17. **I would be better liked if**
18. **I often felt that father**
19. **God to me is**
20. **My children (child) (brothers and sisters)**
21. **Women are**
22. **What hurts me most is**
23. **My biggest problem in life is**
24. **Men are**