



THE HOPE CONNECTION

5319 SW Westgate Dr. Ste. 113
Portland, OR 97221

ADULT INTAKE FORM

DATE: _____

Client Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ Phone: _____

Cell Phone: _____ Email: _____

Insurance Provider: _____ Name of Insured: _____ DOB: _____

Insured Subscriber ID: _____ Group/Policy Number: _____

Presenting reason(s) for seeking services: (check any that apply)

- Anger management Anxiety Addictive behaviors Alcohol/drugs
 Coping Depression Eating disorder Fear/Phobias
 Mental confusion Sexual concerns Sleeping problems Other (please specify)

Comment: _____

Desired outcome or expectations of treatment (changes you would like to make, how we can help)?

Please list any people, organizations or resources you feel can/have/will help you achieve your goal(s):

Please list any potential barriers to achieving your goal(s): _____

Family History

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse / Partner						
Children						

Comments: _____

Parental Information

- Parents legally married Mother remarried: Number of times _____
 Parents have ever been separated Father remarried: Number of times _____
 Parents ever divorced

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.): _____

Significant Others

(brothers, sisters, grandparents, step-relatives, half-relatives, etc. Please specify relationship)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Comments: _____

Marital Status

	Yes	If yes, length of time	Describe current relationship (if applicable)
Single			
Unmarried, living together			
Legally married			
Separated			
Divorce in progress			
Divorced			
Annulment			
Widowed			
Total number of marriages			

Comments:

Development

Are there special, unusual or traumatic circumstances that affected your development? No Yes

If yes, please describe: _____

Is there a history of child abuse? Sexual Physical Verbal. Abuse was as Victim Perpetrator

If yes, please describe: _____

Other childhood issues: Neglect Inadequate nutrition Other (specify) _____

Comments re childhood development: _____

Comments:

Social Relationships

Check how you generally get along with other people: (check all which apply)

Affectionate Aggressive Avoidant Fight/Argue often Follower

Friendly Leader Outgoing Shy/Withdrawn Submissive

Other (specify) _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? No Yes (describe): _____

Comments:

Religion

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Comments:

Medical History

Present Physical Condition: (Include general health and any current medical treatment.) _____

Person to contact in case of emergency: Name: _____ Phone: _____

Please list any known allergies: _____

Past Medical Condition: (List any significant injuries, illnesses or medical conditions for which you have been under medical care). _____

Please list all medications you are currently taking

Medication	Dosage	Prescribed by

Comments: _____

Counseling/Prior Treatment History

Information about client, past and present

	Yes	No	When	Where	Overall reaction to treatment
Counseling					
Psychiatric treatment					
Suicidal thoughts or attempts					
Drug/alcohol treatment					
Hospitalizations					
Self-help groups *					
Other					

*(for example, AA, Al-Anon, NA, Overeaters Anonymous, etc.)

Are there members of your family who have or have had mental health concerns or treatment? _____

Comments: _____

Substance Abuse History

Personal substance use, past and present

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Cocaine/Crack								
Marijuana								
Caffeine								
Nicotine								
Other drugs								

Are there members of your family who have or have had a substance abuse problem? _____

Comments: _____

Education

Fill in all that apply

	Number of years	Currently enrolled		Graduated		Major
		Yes	No	Yes	No	
High school grad/GED						
Vocational						
College						
Graduate						
Other training						

Special circumstances (e.g. learning disabilities, gifted, etc.): _____

Comments:

Employment

Please list your past 3 jobs, beginning with your present one

Employer	Position	Length of Time	Reason for Leaving

Currently:

FT	PT	Temp	Laid-off	Disabled	Retired	Social Security	Student	Other (describe):

Comments:

Military

Branch	Date drafted	Date enlisted	Combat experience		Date of discharge	Rank at discharge	Type of Discharge
			Yes	No			

Comments:

Legal

Current status

Charge	Type			Court	Hearing or trial date
	Traffic	Civil	Criminal		

Are you presently on probation or parole? No Yes (please describe): _____

Past legal history

	No	Yes	If yes, please explain:
Traffic violations			
DWI, DUI, etc.			
Civil involvement			
Criminal involvement			
Other			

Comments:

Therapist signature _____ Date reviewed with client _____