Renew
COUNSELING SERVICES

Intake Form - Adult

Please call 815-290-9711 before completing this form to ensure we can meet your needs and have an opening

Today's Date_____ DOB_____

First Name _____ Last Name _____ Preferred Name_____

Street Address_____

City _____ State _____ Zip Code _____

E-mail_____ Phone_____

Is it ok to call and/or leave a message at this number? (Circle One) YES NO

Primary Care Physician_____PCP Phone_____

Psychiatrist's Name_____Psychiatrist's Phone_____

Describe why you are seeking counseling_____

_____

_____

_____

_____

How long have you been experiencing this problem?_____

Rate the intensity of this problem (1=mild 5=severe)(circle one) 1 2 3 4 5

How does the problem interfere with your day-to-day activities (work, sleep, eating, socializing, etc.)? _____

_____

_____

Please circle all the symptoms you have experienced in the past 3 months

Sadness Hopelessness Sleep too much Fatigue/no energy Poor memory

No Motivation I think about death (my own and others) I feel guilty often

Feel Worthless Not interested in things I used to like Nausea Abdominal pain

I think about suicide I've thought about how I could kill myself Weight gain/loss when not trying

I have a hard time living (working, bathing, doing anything) Pounding heart Sweating

Trembling / Shaking Short of breath Choking / Smothering feeling Chest pain / discomfort

Dizzy / lightheaded Chills / Hot flashes Numbness / tingling Ringing Ears Dry mouth

Muscle tension Can't stop worrying Extreme fear of a certain object (snakes, spider, red things, etc)

Fear of being separated from loved one Hard time figuring out what's reality and what isn't

Fear I will catch a disease Fear I have a disease (even after doctor says I don't)

Spend time looking up symptoms to illness Experienced a threat to my life (anytime, not just past 3 mo)

No Need for Sleep Talk too Fast Irritable/Angry Can't Fall asleep Can't stay asleep

Too Much Energy Hear Things I'm not sure are there

Not Hungry Prefer Being Alone Impulsive Can't Concentrate Restless

Suspicious See Odd Things Have Special Powers Repeated Nightmares

Nervous Fearful Panic Attacks Can't be in Crowds Avoid people/things

Anxiety Easily Startled Excessive Worry Decreased Libido Reoccurring

Increased Risky behavior I feel like I'm being watched I feel like people are out to get me

Who referred you for counseling services?_____

Have you received mental health services in the past? YES NO

If so, whom did you see and
when?_____

Have you ever been hospitalized for a mental health illness? YES NO If so, please list where and
when_____

Are you currently on any prescribed medications for mental health? YES NO If so, please list each medication and dose

_____

_____

_____

Please list any family history of mental illness (parents, aunts, grandparents, siblings, children, cousins, etc.?)

_____

_____

_____

Please list any physical health problems you have experienced in the past year

_____

_____

Please list any regular medication you are on_____

_____

Do you use tobacco? YES NO
Would you or someone you know say you are having a problem with alcohol? YES NO
Would you or someone you know say you are having a problem with pills or illegal drugs? YES NO
Would you or someone you know say you are having a problem with other addictions (gambling, shopping, porn, video games, etc.)? YES NO
Is there a family history of addiction in your family? YES NO

Are you adopted? YES NO Where did you grow up?_____

Do you have siblings? YES NO If yes please list brother/sister and approximate age_____

_____

How would you describe your current relationship with your siblings?_____

_____

Are you parents living? YES NO If yes, how would you describe your relationship with your parents?_____
Are/Were your parents divorced? YES NO

Do you have a history of being abused emotionally, sexually, physically, or by neglect? YES NO
If yes, please give any details you are willing to share_____

_____

_____

Highest grade you completed_____ Are you currently employed? YES NO
If so
where?_____Jobtitle_____

Have you ever served in the military? YES NO If yes, what branch?_____ When?_____

Honorable discharge? YES NO If no, please share what you are willing _____

_____

Please circle one: I am MARRIED SINGLE DIVORCED WIDOWED LIVING TOGETHER
If married or living together how long?_____How would you describe this relationship?_____

_____

Do you have previous marriages? YES NO Do you have children? YES NO If yes, please list names and ages_____

_____

Describe your relationship with your children_____

List everyone who currently lives with you_____

_____

Please describe your spiritual life (believe in God/don't, am a Christian, attend church, believe in prayer, I'm not sure)_____

_____

_____

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

_____

Therapy at Renew Counseling is client centered and solution focused. Successful therapy follows a good plan including well thought out goals. Please take some time to think about what you want to work on during your sessions.

If you know some goals you want to address please list them here_____

_____

_____

_____

_____

_____

_____

_____

If you aren't sure, please look at the list below and circle anything you think might fit as a goal for you.

Setting boundaries	Building a relationship with_____
Expressing feelings appropriately	Working on my relationship with _____
Managing anger	Learning new parenting skills
Dealing with sadness	Dealing with grief
Sleeping better	Learning how to cope with _____
Learning how to relax	Dealing with anxiety
Decreasing panic	Reducing alcohol/drug use
Finding motivation again	Improving my relationship with_____
Controlling myself better	Improving my marriage
Improving my self-esteem	Learning to care for myself better
Decrease/eliminate suicidal thoughts	Reduce/stop harming myself
Decrease unwanted thoughts	Feel less nervous

Answer this question as well as you can: If you woke up in the morning and your problems miraculously vanished, what would life be like? How would you know the problem was gone? What would you be doing? How would you be feeling? _____

_____

_____

_____

_____

Signature:_____ Date:_____