Healing heARTS Counseling, LLC
Bend, Oregon
(541) 668-7613

Adult Intake Form

Basic Information

Client Name:_____ Date of Birth:_____

Age:_____ Birth Sex:_____Gender Identity:_____

Race:_____Ethnicity:_____

Address:_____

Phone Number: (Home)_____(Cell)_____

Email address:_____

May we leave a message or email? Yes☐ No☐

Emergency Contact/Relationship and Phone Number:_____

_____

Have you previously received counseling services? Yes_____No_____

Name of Counselor/Agency:_____

Year Seen:_____Reason Seen:_____

Family Information

Primary Household Occupants (anyone currently living with you):

Name	Age	Gender	Relationship to You

Please list your siblings and their current ages:_____

_____

Describe your childhood(Ex: Safe, Happy, Sad, Scary, etc):

If your parents are divorced, when did divorce occur?

How old were you when parents divorced?

How did you respond to the divorce?

Any current conflict within the family?

Educational and Work Information

Highest Grade Level Complete:

Are you currently working?___Yes___No What is your occupation?

Where do you work? _____ How long have you been there?

Medical Information

Primary Doctor:

Current diagnosis or medical concerns:

List any recent or current medications:

Have you ever attempted suicide?___Yes ___No If yes, please describe the nature of the event and the date(s) of occurrence.

List any substances (including Caffeine and Tobacco) that you are currently taking or have taken in the past and include the frequency of use and the last date of use:

Have you ever felt that you were abusing drugs or alcohol?___Yes___No If so, please describe when and the nature of the problem.

Relationship History

Are you currently ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living Together

How long? _____ What is your sexual orientation? _____

List any stressors or problems in your relationship: _____

_____

If married/living together, what is your partner's occupation? _____

Have you been married before (or in a long term committed relationship)? ☐ Yes ☐ No

How many times? _____ How long did these relationships last? _____

If you have children, what are their names and ages? _____

_____

Do you belong to any religious/spiritual organizations and/or support groups?: _____

Any hobbies?: _____

Presenting Issues

Please describe why you are seeking counseling. _____

_____

_____

_____

_____

_____

_____

Presenting Issues Questionnaire

Only check "yes" if the issue described cause you significant distress and/or cause problems at home, work or in relationships.

Yes ☐ No ☐ Do you frequently have difficulty getting to sleep or staying asleep?

Yes ☐ No ☐ Does lack of sleep make you feel unrested or cause you to function poorly during the day?

Yes ☐ No ☐ Do you have anxiety or worry excessively (more than the average person) about things such as work, finances, loved ones?

Yes ☐ No ☐ Do you find it difficult to control worry and anxiety?

Yes ☐ No ☐ Do you have unexpected or "out of the blue" periods of intense fear associated with symptoms such as shakiness, shortness of breath, and/or racing heart?

Yes ☐ No ☐ Do you experience intense feelings of anxiety or fear that you will be humiliated or embarrassed in front of others?

Yes___ No___ Do you avoid or anxiously endure things such as speaking in public, parties, dating, writing or eating in front of others?

Yes___ No___ Are you bothered by intrusive thoughts or mental images?

Yes___ No___ Do you have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control your anxiety or distress?

Yes___ No___ Have you experienced a traumatic event(s) that threatened or actually caused serious physical injury to yourself or others?

Yes___ No___ As a result, do you have significant stress such as flashbacks, nightmares, persistent anxiety, or feelings of emotional numbness?

Yes___ No___ Do you have times when you feel depressed or down most of the day, nearly every hour?

Yes___ No___ Have you lost interest, motivation, or pleasure in usual activities?

Yes___ No___ Do you have chronic difficulties paying attention?

Yes___ No___ Do you find it hard to be still?

Yes___ No___ Do you sometimes act before you think?

Yes___ No___ Do you have distinct periods of time when you are different than your normal self – you either feel high/full of energy, or are persistently angry?

Yes___ No___ Does this behavior cause you, or others, problems? (Don't include alcohol or drug related states.)

Yes___ No___ Have you, or others, been concerned about your alcohol consumption?

Yes___ No___ Have you tried to cut down or felt guilty about drinking alcohol?

Yes___ No___ Do you have eating binges at times when you eat a very large amount of food within a two-hour period?

Yes___ No___ Do you use tobacco (cigarettes, snuff, chewing tobacco)?

Yes___ No___ Do you take drugs to get high, feel better, or change your mood?

Yes___ No___ Do you use illegal drugs?

Yes___ No___ Do you have a lack or loss of interest in sex or decreased arousal?

Yes___ No___ Have other people expressed concern that you are too thin?

Yes___ No___ When you were a child, and perhaps as an adult, did you have difficulty making friends, or did you not want to make friends?

Yes___ No___ Did you have, or perhaps still do, difficulty understanding other people's feelings?

Yes___ No___ Did you have, or perhaps still do, a special interest(s) that took up much of your time?

Life Trauma Inventory

1. Yes___ No___ Have you ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion)?

2. Yes No Have you ever seen a serious accident (for example, a bad car wreck or an on-the- job accident)?

3. Yes No Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)?

4. Yes No Was a close family member ever sent to jail?

5. Yes No Have you ever been sent to jail?

6. Yes No Were you ever put in foster care or put up for adoption?

7. Yes No Did your parents ever separate or divorce while you were living with them?

8. Yes No Have you ever been separated or divorced?

9. Yes No Have you ever had serious money problems (for example, not enough money for food or a place to live?

10. Yes No Have you ever had a very serious physical or mental illness (for example cancer, heart attack, serious operation, felt like killing yourself, hospitalized for nerve problems)?

11. Yes No Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were "no good")?

12. Yes No Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?

13. Yes No Have you ever had an abortion or miscarriage?

14. Yes No Have you ever been separated from your child against your will (for example, the loss of custody or visitation or kidnapping)?

15. Yes No Has a baby or child of yours ever had a severe physical or mental disability?

16. Yes No Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental disability (for example, cancer, stroke, AIDS, nerve problem, dementia, can't hear, see, walk)?

17. Yes No Has someone close to you died suddenly or unexpectedly?

18. Yes No Has someone close to you died NOT suddenly or unexpectedly?

19. Yes No When you were young (before age 16) did you ever see violence between family members (for example, hitting, kicking, slapping, punching)?

20. Yes No Have you ever seen a robbery, mugging, or attack taking place?

21. Yes No Have you ever been robbed, mugged or physically attacked (NOT sexually) by someone you did not know?

22. Yes No Before age 17, were you ever abused or physically attacked (NOT sexually) by someone you knew (for example, a parent or partner hit, slapped, choked, burned, or beat you up)?

23. Yes No After age 17, were you ever abused or physically attacked (NOT sexually) by someone you knew (for example, a parent or partner hit, slapped, choked, burned, or beat you up)?

24. Yes No Before age 17, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?

25. Yes No After age 17, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?

26. Yes No Before age 17, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't?

27. Yes No After age 17, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?

28. Yes No Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a coworker, a boss, a customer, another student, a teacher)?

29. Yes No Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it?

30. Yes No Are there any events we did not include that you would like to mention? Please explain:_____

_____

_____

By signing this document below, I agree that the above information is true to the best of my knowledge.

_____
Client Name (Print)

_____ _____
Client or Parent/Legal Guardian Signature Date