

Fernie Counselling & Consulting
Specializing in Child and Family Care



ADULT INTAKE

PERSONAL INFORMATION

Name_____

Phone_____ Cell_____

Do you text_____ Email_____

Date of Birth_____

Highest Grade you completed_____

College Student?_____ What College_____

Do you work outside the home?_____ Disability?_____

Place of Employment_____

Address_____

City_____ Province_____ Postal Code_____

Phone_____

Spouse or Partner Information

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone_____ Cell_____

Date of Birth_____

Highest Grade they completed_____

College Student?_____What College_____

Does your Spouse or partner work outside of the home?_____

Disability?_____

Place of Employment_____

Address_____

City_____State_____Zip Code_____

Phone_____

Children_____Names and Ages_____

Where do they live today?_____

Emergency Contact Person_____

Relationship to you_____Phone_____

FAMILY BACKGROUND

Mother_____

City _____Province_____

Occupation_____

Father_____

City _____ Province _____

Occupation _____

Siblings (name and age) _____

Circle the sibling you were closest to growing up.
Put a square around the sibling you are closest to now.

Did anyone else raise you? (Nanny, Auntie, Grandmother
etc.) _____ Why _____

List all of the places that you lived _____

Which one was favorite _____

Which one was your least favorite _____

ABOUT YOU

List your favorite activities _____

What brings you joy _____

What is your least favorite thing to do _____

List your fears_____

Have you ever been to Therapy
before?_____

Length of time_____

What do you hope to accomplish in therapy_____

Were you: (in your childhood and/or as an adult)

Sexually Abused_____

Physically Abused_____

Verbally Abused_____

Psychologically Abused _____

Ritually Abused_____

What Medications are you currently taking_____

What Herbal remedies are you currently taking_____

How do you cope with stress_____

Do you have a problem with Porn? _____
 Would your partner or family agree with you? _____
 Do you have a problem with Drinking? _____
 Would your partner or family agree with you? _____
 Do you have a problem with drugs? _____
 Would your partner or family agree with you? _____
 Do you have a problem with cutting? _____
 Would your partner or family agree with you? _____
 Do you have a problem with an eating disorder? _____
 Would your partner or family agree with you? _____
 Do you have a gambling or spending problem? _____
 Would your partner or family agree with you? _____

Is there a reoccurring complaint about you that a partner,
 spouse, or family member makes ? _____

HOW ARE YOU FEELING (circle all that apply)

- | | | | |
|-------------|--------------|-------------|------------|
| Angry | Sad | Confused | Lonely |
| Lost | Joyful | "Different" | Suspicious |
| Content | Bitter | Happy | Betrayed |
| Humiliated | Distrustful | Grateful | Depressed |
| Silly | Disheartened | Anxious | Ashamed |
| Frustrated | Exhausted | Overwhelmed | Jealous |
| Embarrassed | Scared | Shocked | Enraged |
| "Crazy" | Blessed | Confident | Guilty |
| Suicidal | Hopeful | Pissed | Paranoid |
| Melancholy | Dissociative | Jazzed | Alone |

Have you ever been in a 12 Step Program? _____
Which one _____

Have you ever admitted yourself or been admitted to:

_____ Inpatient Psychiatric Facility

_____ Drug and Alcohol Treatment Facility

_____ Detox Center

_____ Eating Disorder Treatment Facility

_____ Other Treatment Facility (DID, PTSD, Gambling, etc)

What is your drug of choice? _____

What is your fall-back addiction? _____

How long have you been clean and sober? _____

Do you have a sponsor? _____

Have you ever attempted Suicide? _____

When? _____

Were you hospitalized? _____

Where? _____

Are you suicidal now? _____

If so, what is keeping you alive at
present? _____