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_____

<u>FAMILY BACKGROUND</u>

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_____

<u>ABOUT YOU</u>

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?_____