Gina Candelaria, M.Ed., M.C., LPC

Adult Intake-Confidential History

Name: ____Date: _______________

Address: ____

Street City State Zip

Phone: ______________________________ Date of Birth: __________________

Gender: Male___ Female___ Age: __________

May I contact you at home? __Yes __No by Mail? __Yes __No

Emergency Contact: ____

Person/Relationship Phone #

Referred by: ____

Education Level: ____________________ Occupation: _____________________

Are you satisfied with your current occupation? __Yes __No Comments: _______

____

Your Marital Status:

__Married __Living Together __Never Married __Divorced __Remarried

__Separated __Custodial Parent Remarried __Non-Custodial Parent Remarried

Are there current marital problems? __Yes __ No
Comments:____

Spouse's Name: __________________________ Level of Education:____________

Spouse's Occupation: ___________________ Satisfied with job? __Yes __No

Your Children:

Name: ___________________________________ Sex: M F Age: _________

Name: ___________________________________ Sex: M F Age: _________

Name: ___________________________________ Sex: M F Age: _________

Name: ___________________________________ Sex: M F Age: _________

Pets: ____

Are your parents still living? __ Yes __ No When passed? __________________

Mother's Name: _____________________________ **Stepmother?** __Yes __No

Occupation: _____________________________ Level of Education: ____________

Father's Name: _____________________________ **Stepfather?** __ Yes __No

Occupation: _____________________________ Level of Education: ____________

Your Siblings:

Name: ___________________________________ Sex: M F Age: _________

Name: ___________________________________ Sex: M F Age: _________

Name: ____________________________________ Sex: M F Age: _________

With whom were you raised? (check all that apply)

__Biological Parents __Parent & Step-parent __Foster Parent __Single Parent

__Adoptive Parents __ Relatives __Institution __Legal Guardian __Other

Marital Status of Parents: (check all that apply) **Years Married:** __________

__Married __Living Together __Never Married __Divorced __Separated

__Custodial Parent Remarried __Non-Custodial Parent Remarried

<u>MEDICAL HISTORY:</u> Please list any major **medical conditions in your family.**

____

____

____

<u>Please list YOUR</u> medical conditions or health issues:

____

____

____

Current Physician: ______________________________Ph: ____________________

Date of most recent visit: ____________ Reason: ___________________________

<u>MEDICATIONS YOU TAKE</u>:

Medication Name	**Dosage**	**Prescribing Doctor**	**Reason**

Please list any **significant accidents or injuries** you've had and when they occurred.

____

Is there **family history of psychological/psychiatric conditions**? __Yes __No

Comments: ____

Is there **family history of problems with drugs and/or alcohol?** __ Yes __ No

Comments: ____

____

Have you had previous counseling? __Yes __No

With whom and when: ____

Have you ever felt suicidal? __Yes __No Comments: ________________________

____

Do you feel that way now? __ Yes __No Comments:_________________________

____

Are you involved in any Legal Matters/ Proceedings: ___Yes ___ No

Comments: ____

Have you ever been arrested? __ Yes __No Convicted of a crime? __Yes __No

Have you been a victim of physical or sexual abuse/assault? __Yes __No

Comments: ____

What are your main reasons for seeking Counseling? _________________________

____

Did a specific event lead to this session? __Yes __ No

WHEN did your concerns first start? ____________________________________

WHAT have you tried on your own to solve the concerns?

____

What changes do you want to see as a result of Counseling? __________________

____

OTHER COMMENTS: ____

____

Thank you for sharing this information with me. Gina Candelaria

____

Client's Signature Print Name Date